Health Care Financing

Program Statistics

Medicare and Medicaid Data Book, 1984

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Health Care Financing Administration

Health Care Financing

Program Statistics

The Health Care Financing Administration (HCFA) was established to combine health financing and quality assurance programs within a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of other health care quality assurance programs.

The mission of HCFA is to promote the timely delivery of appropriate and quality health care to the 29.0 million Medicare enrollees and the 21.6 million Medicaid recipients among the Nation's aged, disabled, and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

The Office of Research and Demonstrations (ORD) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility, and management alternatives to the present Federal programs. In addition, ORD examines the impact of HCFA programs on health care status, utilization, and expenditures, as well as their effect on beneficiary access to services, health care providers, and the health care industry.

The Bureau of Data Management and Strategy (BDMS) operates HCFA's statistical data systems and maintains the national Medicare statistical files. BDMS also serves as the focal point within the agency for information systems policy, planning, and data standards development.

The Office of the Actuary (OACT) directs the actuarial program for HCFA and monitors national health care expenditures and prices. OACT also provides analyses on the costs of current HCFA programs and the impact of possible legislative or administrative changes in the programs.

The Medicare and Medicaid Data Book, 1984 is the third edition of a report that provides an overview of the Medicare and Medicaid programs. This report presents basic data and analyses of the programs. It includes trends on enrollees, recipients, use of services and expenditures, and describes various aspects of the two programs. It also provides lists of Medicare carriers and intermediaries, Medicaid agencies and fiscal agents, and Agency offices to call for information.

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Medicare and Medicaid Data Book, 1984

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Symbols	
—	Data not available
NA	Not applicable
Z	Percentage more than 0 but less than 0.05

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Medicare and Medicaid Data Book, 1984

by Martin Ruther, Aileen Pagan-Berlucchi, Valerie Rinkle, and Joanne Yanek

Executive summary

This volume is the third in a series of descriptive statistical reports on the Medicare and Medicaid programs. Previous reports in this series were the 1981 and 1983 editions of *The Medicare and Medicaid Data Book* (Muse and Sawyer, 1982; Sawyer et al., 1983). The 1983 *Data Book* presented Medicare data for calendar year (CY) 1980 and Medicaid data for fiscal year (FY) 1980. This report presents Medicare data for CY 1981 and Medicaid data for FY 1981 and 1982. The volume is intended to serve as a resource for public officials, researchers, policy analysts, and consumers who have an interest in these health programs.

The report has four chapters. In Chapter 1, brief overviews of Medicare and Medicaid are provided, and information is presented on the relationships between these two programs, Federal administration of the programs, and comparative program expenditures.

Medicare and Medicaid program highlights from Chapter 1 include:

- In CY 1981, reimbursements were made for 18.9 million of the 29.0 million aged and disabled Medicare enrollees. Medicare reimbursements for health services totaled $40 billion. In FY 1981, 22.0 million Medicaid recipients (persons who received Medicaid services) had a total of $27.2 billion paid on their behalf. In FY 1982, the comparable figures were 21.6 million recipients and $29.4 billion in payments.
- In CY 1981, the average Medicare payment per reimbursed enrollee was $2,108. The average Medicaid payment per recipient was $1,238 in FY 1981 and $1,361 in FY 1982.
- Nearly two-thirds of the total Medicare reimbursements in CY 1981 were for inpatient hospital care. In contrast, long-term care (care in intermediate and skilled nursing facilities) made up a large portion of Medicaid payments in FY 1982—43.8 percent.
- Aged persons made up 90 percent of all Medicare enrollees in CY 1981, and they received 87 percent of all reimbursements. The remainder of the Medicare enrollees were disabled persons, including persons with end-stage renal disease.
- The largest proportion of Medicaid recipients were children and adults who became eligible through the Aid to Families With Dependent Children (AFDC) program. The Dependent Children program comprised 69 percent of all recipients, but they received only 26 percent of total Medicaid payments in FY 1982.

Chapter 2 reports trends in the evolution of the Medicare and Medicaid programs. Trends in the number of Medicare enrollees and Medicaid recipients, Medicare and Medicaid expenditures, and the use of and expenditures for hospital inpatient and physicians' services in both programs are described. Trend data for other services in each program, including Medicaid long-term care utilization and expenditures, are also presented. Trends in the use of Medicare services by persons with end-stage renal disease are reported for the first time. The chapter ends with new material on the evolution of Medicare and Medicaid from their beginning to the present. Changes in Medicare policy to control hospital care costs are described and changes in the factors determining Medicaid expenditures are analyzed.

Highlights of Medicare and Medicaid program trends reported in Chapter 2 include:

- During the period 1966-81, the number of aged and disabled Medicare enrollees increased each year at an average annual rate of 2.8 percent.
- The average age of aged Medicare enrollees also increased. The proportion of enrollees 75 years of age or over grew faster than the proportion 65-74 years of age. This gradual aging has long-term effects because older enrollees are relatively high users of health care services and raise the average amount reimbursed per enrollee.
- From 1973 to 1982, the number of Medicaid recipients increased 1.1 percent per year. This overall upward trend included periods of both growth and decline.
- Total Medicare reimbursements grew 17.5 percent per year during the period 1967-81.
- Total Medicaid expenditures increased at an average annual rate of 14.6 percent during the period 1973-82.
- From 1967 to 1981, Medicare reimbursements for inpatient hospital services increased from 62.7 percent to 66.3 percent of total reimbursements. The proportion for skilled nursing facility services decreased from 6.5 percent to .9 percent in the same period.
- In 1981, aged Medicare enrollees for whom reimbursements were $15,000 or more represented only 1.4 percent of aged enrollees but accounted for 25.5 percent of all Medicare reimbursements for the aged. In contrast, among disabled Medicare enrollees, 2.7 percent were reimbursed $15,000 or more, and this group accounted for 42.3 percent of all reimbursements for the disabled. Of the disabled, 44.2 percent received no reimbursement.
- In FY 1982, aged, blind, and disabled persons comprised 28.4 percent of all Medicaid recipients but accounted for 71.9 percent of all Medicaid payments. Children in the Aid to Families With Dependent Children category accounted for 44.3 percent of all Medicaid recipients and only 11.8 percent of all Medicaid payments.

Elvira Fussell and Elizabeth Webster contributed in the preparation of the tables and the typing of this report.

- In 1974, the first full year of Medicare coverage for end-stage renal disease (ESRD) patients, their reimbursements were $229 million. By 1981, reimbursements for ESRD patients amounted to $1,466 million, an average annual increase of 30 percent.
- Reimbursements per ESRD enrollee rose from $14,300 in 1974 to $22,900 in 1981, an annual growth rate of only 7 percent. This low rate is largely attributable to a limit on charges for kidney dialysis treatments.

In Chapter 3, the major characteristics of the Medicare program are described, and supporting program statistics are presented. Medicare eligibility, benefits, financing, and administration are outlined for both the hospital insurance and supplementary medical insurance programs. Data are presented on enrollment and expenditures for both the aged and disabled. Detailed information is provided on Medicare financing and administration, the use of Medicare benefits, and the distribution of reimbursements for various services by different categories of enrollees.

Chapter 3 concludes with a description of Medicare's arrangements with group practice prepayment plans and health maintenance organizations and with a discussion of the Medicare statistical system, including a description of new data on reimbursement for physicians and suppliers of services.

Highlights for Chapter 3 on the Medicare program are as follows:

Persons served and reimbursement per person, 1981

- Much larger proportions of aged and disabled enrollees received supplementary medical insurance (SMI) benefits than hospital insurance (HI) benefits. However, for both the aged and the disabled, average payments per person served were far higher for HI than for SMI.
- The proportion of aged enrollees receiving various types of Medicare benefits was successively higher with increasing age.
- By far the largest proportion of aged enrollees received benefits for physicians' services, followed by outpatient and then inpatient hospital services.
- Larger proportions of aged whites than persons of other races received Medicare benefits for inpatient hospital, skilled nursing, and physicians' services. However, aged persons other than white received greater proportions of outpatient and home health services.
- Aged persons other than white had higher reimbursements per person served than white persons for all services except physicians' services.
- Except for inpatient hospital benefits, a larger proportion of aged women than men received benefits.
- Reimbursement per aged person served was highest for inpatient hospital services ($3,806), followed by skilled nursing facility services ($1,486), and home health agency services ($724). Comparable figures for SMI were physicians' services ($530) and outpatient services ($219).

Hospital insurance benefits, 1981

- For both aged and disabled enrollees, the number of short-stay hospital discharges per 1,000 enrollees and covered days of care per 1,000 enrollees increased with age.
- The discharge rate for white persons exceeded that for all others among both aged and disabled enrollees. However, aged and disabled persons of other races had longer average lengths of stay and higher reimbursements per discharge than white persons had.
- The proportion of the aged who received skilled nursing facility (SNF) benefits was over three times higher than that of the disabled.
- Among both the aged and disabled, higher proportions of females than males received SNF benefits.

Supplementary medical insurance benefits, 1981

- The proportion of persons receiving reimbursement for physicians' services was similar for aged and disabled enrollees. However, average reimbursements were nearly one-third higher for disabled than for aged persons.
- For both aged and disabled enrollees, the reduction in reasonable (allowed) physician charges made by Medicare carriers was 25 percent.
- Among the aged, Medicare reimbursed 65.6 percent of physicians' charges due (total charges less the reduction amount on unassigned claims). The remainder, 34.4 percent, was the liability of the Medicare patient. It consisted of: coinsurance, 15.6 percent; reduction on unassigned claims, 13.5 percent; and deductible, 5.3 percent.
- For outpatient services, both the proportion of persons reimbursed and their average reimbursement were higher for disabled than for aged enrollees. This reflects, in part, the use of dialysis services by disabled persons with ESRD.

Group plans

- As of March 1983, only 2 percent of the total Medicare population were members of group practice prepayment plans or health maintenance organizations.

Detailed data on the Medicaid program are reported in Chapter 4. Descriptions of Federal rules and State options are followed by information on States' provisions for eligibility and benefits. Statistical data on service use and expenditures are presented for each Medicaid jurisdiction. During the development of this publication, when Federal and State Medicaid data were found to differ, State data were used. Hence, these data may differ slightly from those found in other Health Care Financing Administration publications.

Chapter 4 also describes Medicaid financing and administration, including matching rates for Federal financial participation, recipients and expenditures under State

"buy-ins" to Medicare, number of certified providers, implementation of the Medicaid Management Information System, Federal Medicaid assistance percentages, and the Medicaid data system.

Highlights for Chapter 4 on the Medicaid program are:

Number of Medicaid recipients and payments, FY 1982

- Medicaid recipients totaled 21.6 million, of whom 74.6 percent were in cash assistance programs. These recipients accounted for 54.1 percent of total vendor payments.
- Sixty-nine percent of all recipients were covered under the AFDC program, but they accounted for only 25.7 percent of all vendor payments.
- The disabled accounted for 34.8 percent of total payments and only 13.0 percent of total recipients.
- Females accounted for 64 percent of all recipients and 66.6 percent of total vendor payments.

Services used, FY 1982

- Recipients 65 years of age and over were the most frequent users of skilled nursing facility (SNF), intermediate care facility (ICF), home health, and other medical services. This group accounted for the largest share of total vendor payments (36.5 percent) but represented only 15.0 percent of all recipients.
- In reporting States, 29.4 percent of all vendor payments were for inpatient hospital services (including general and mental hospitals), followed by payments for ICF's (28.7 percent) and SNF's (15.1 percent).

Federal Medicaid assistance percentage

- The Federal share in Medicaid is determined on the basis of State per capita income. For FY 1983-85, 17 States will receive the minimum Federal Medicaid assistance percentage of 50 percent. Mississippi, the State with the lowest per capita income, will receive the highest share, 77.6 percent.

This volume contains several appendixes that are designed to facilitate understanding of the material and identify additional sources of information. Names and addresses are listed for Medicare intermediaries and carriers. Telephone numbers are supplied for Medicaid State agencies and medical assistance programs and for the Health Care Financing Administration offices responsible for various facets of the Medicare and Medicaid programs. A glossary and a list of acronyms used in this report are also included.

1. Introduction to Medicare and Medicaid

In this chapter, the major characteristics of the Medicare and Medicaid programs are outlined. Information is also presented on the relationship between the two programs, including the relationship between Medicare and Medicaid for persons jointly eligible under both programs (''dual eligibles''). New material about the use of Medicaid services is provided from the National Medical Care Utilization and Expenditure Survey. Other topics covered are how the Federal Government is organized to administer both programs and how much each program spends, in total and per enrollee or per recipient in each State.

Overview of the Medicare program

The Medicare program covers hospital, physician, and other medical services for most persons 65 years of age or over, disabled persons entitled to social security cash benefits for at least 24 months, and most persons with end-stage renal disease. Total Medicare expenditures, as reported by the Medicare trust funds, were $43.5 billion in calendar year 1981.

Medicare has two complementary but distinct parts: hospital insurance (HI), also called Part A, and supplementary medical insurance (SMI), also called as Part B. The HI program covers 90 days of inpatient hospital care in a benefit period (spell of illness), which begins with the first day of hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 continuous days. There is no limit to the number of benefit periods an individual may use. The program also provides a lifetime reserve, a nonrenewable reserve of 60 days that can be used if a beneficiary exhausts the 90 days available in a benefit period.

In addition to inpatient hospital care, the HI program covers up to 100 post-hospital days in an SNF if the beneficiary is certified to require such care. It also covers home health agency (HHA) visits. Some restrictions on HHA visits were removed by the Omnibus Budget Reconciliation Act of 1980 (Public Law 96-499). Effective July 1981, prior hospitalization is not required for covered HHA visits, and the limit of 100 visits no longer applies.

About 95 percent of the Nation's aged are enrolled in the HI program. On July 1, 1966, when Medicare became operational, 19.1 million aged persons were enrolled. By July 1, 1982, the number of aged and disabled enrollees had increased to 29.5 million. This total includes 3.0 million disabled enrollees. Medicare coverage of the disabled began on July 1, 1973.

Nearly everyone covered by HI voluntarily enrolls in SMI. Unlike HI, SMI requires a monthly premium payment—$14.60 per month as of January 1984. Under ''buy-in'' agreements, most State Medicaid programs pay these premiums for persons who qualify for both Medicaid and Medicare benefits. The SMI program provides payments for physicians as well as related services and supplies ordered by physicians. SMI also covers outpatient hospital services, rural health clinic visits, and home health visits.

Some frequently used types of health care, such as drugs, dental care, routine eye examinations, and preventive services, are not covered by Medicare. Drugs and certain dental procedures are covered only if provided during an authorized hospital inpatient stay. Also, neither intermediate nursing care nor long-term nursing care are covered by Medicare.

Both the HI and SMI programs require beneficiary cost sharing. Under HI, the patient is required to pay an inpatient hospital deductible for each benefit period. This deductible ($356 in 1984) approximates the cost of 1 day of hospital care. Coinsurance, the amount of which is based on the inpatient hospital deductible, is required. For the 61st-90th day of inpatient hospital care, coinsurance equals one-fourth of the hospital deductible; for the 21st-100th day of skilled nursing facility care, it equals one-eighth of the deductible; and for the 60 lifetime reserve days of inpatient hospital care, it equals one-half of the deductible. The patient is also liable for the cost or replacement of the first three pints of blood in a benefit period.

Under SMI, in addition to paying a monthly premium, the beneficiary must pay a $75 deductible each year. (The deductible was raised from $60 to $75 by the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, effective January 1, 1982.) Physicians can accept or reject assignment on each claim for payment. Acceptance of assignment means the physician agrees to accept as full payment the amount Medicare allows for the service. The program reimburses 80 percent of allowed (reasonable) charges directly to the physician. Beneficiaries are liable for the remaining 20 percent of allowed charges (coinsurance). On unassigned claims, the beneficiary is also responsible for the difference between the physician's charge and the allowed charge. (See ''Benefits under SMI'' in Chapter 3, for more details.) The Medicaid program assumes cost sharing for Medicaid beneficiaries covered under ''buy-in'' agreements. As of calendar year 1982, 46 States had a ''buy-in'' program. (Buy-in agreements for duel eligibles are discussed in more detail later in this chapter.)

Medicare benefits and administrative expenses are paid from two separate trust funds. The HI trust fund is financed primarily through a tax on current earnings from employment covered under the Social Security Act. The SMI trust fund is financed through premiums paid by or on behalf of persons enrolled in the program and from general revenues of the Federal Government.

Overview of the Medicaid program

Medicaid is a federally supported and State-administered assistance program providing medical care for certain low-income individuals and families. Medicaid accounted for $29.4 billion in Federal and State expenditures for medical services in fiscal year 1982.

The program is designed to provide medical assistance to people who are eligible to receive cash payments under one of the existing welfare programs established

under the Social Security Act: Title IV-A, the program of Aid to Families With Dependent Children (AFDC), or Title XVI, the Supplemental Security Income (SSI) program for the aged, blind, and disabled. These people are considered "categorically needy." In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid.

In addition, States may provide Medicaid to the "medically needy," that is, people who: (1) fit into one of the categories of people covered by the cash assistance programs (aged, blind, disabled, or members of families with dependent children when one parent is dead, absent, incapacitated, or, at State discretion, unemployed), and (2) are not recipients of cash assistance but have income below a specified level. Chapter 4 contains a more detailed discussion of the major differences among jurisdictions in the criteria used to determine program eligibility.

Title XIX of the Social Security Act requires that every State Medicaid program offer certain basic services: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, skilled nursing facility services for individuals 21 years of age or older, home health services for individuals eligible for skilled nursing services, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis, and treatment services for individuals under 21 years of age. In addition, States may elect to provide a number of other services, including drugs, eyeglasses, private-duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21 years of age, physical therapy, and dental care.

Medicaid is a vendor payment program; payments are made directly to service providers for care rendered to eligible individuals. Providers who choose to participate in the program must accept the Medicaid reimbursement levels as full payment. Individuals in long-term care institutions must turn over income in excess of their personal needs and maintenance needs of their spouses to help pay for their care. States may not require the categorically needy recipients to share costs for mandatory services, but they may require other Medicaid recipients to share in the cost of certain services. The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) now permits States to require cost sharing by certain categorically needy recipients.[1] As noted earlier, most State Medicaid programs have buy-in agreements with Medicare. Under these agreements, Medicaid pays the SMI Medicare premiums and cost sharing for persons covered under both programs.

Medicaid is financed jointly with State and Federal funds. Federal contributions, which vary with States' per capita income, currently range from 50-78 percent of program medical expenditures. Administration, fraud and abuse, and Medicaid Management Information System development and operation costs are matched at other rates.

States participate in the Medicaid program at their option. All States except Arizona currently have Medicaid programs.[2] The District of Columbia, Puerto Rico, Guam, the Northern Marianas, and the Virgin Islands also provide Medicaid coverage. States administer their Medicaid programs within broad Federal requirements and guidelines. These requirements allow States considerable discretion in determining income and other resource criteria for eligibility, covered benefits, and provider payment mechanisms. States that include medically needy (or "State-only") persons in their Medicaid program receive no Federal contribution for the cost for that group of recipients. As a result, the characteristics of Medicaid programs vary considerably from State to State.

Comparative view of Medicare and Medicaid

Medicare and Medicaid data

The marked differences in the statistical systems supporting the Medicare and Medicaid programs obviously limit the comparisons that can be made across the two programs. In this section, some of the differences between the two statistical systems that relate to the data presented in this report are discussed.

The Medicare statistical system collects data on enrollees, that is, persons eligible for Medicare. In addition, data are shown for enrollees who received services for which reimbursements were made (referred to as "persons served"). In contrast, Federal Medicaid statistics consist of aggregate counts of the number of recipients (as opposed to enrollees).

Most of the Medicare statistics in this report are produced from the Medicare statistical system, which contains all claims processed in the Central Office of the Health Care Financing Administration (HCFA) in Baltimore. The Central Office also tabulates data on the services used by each person reimbursed. Medicaid statistics also are centrally maintained in the Central Office, but only after they have been aggregated into recipient and expenditure counts by the States. These data are reported to HCFA by the Medicaid jurisdictions on form HCFA-2082. Thus, unlike most Medicare data, HCFA data on the Medicaid program cannot be disaggregated by individual person or service. Thus, Medicaid statistics are more limited in use than Medicare statistics are.

The Medicare claims data presented in this volume are generally reported for the calendar year in which medical services were rendered rather than the date when Medicare payment was made. Conversely, Medicaid recipient and expenditure counts included here were reported for the fiscal year in which services were paid. For more information on the data systems of Medicare and Medicaid see the last section of Chapters 3 and 4, respectively.

Interrelated coverage

Through State buy-in agreements, about 11 percent of aged and disabled Medicare enrollees are also covered by

[1] The act also made a number of other changes in the Medicaid program, such as allowing for coverage of home care for certain disabled children and the establishment of a Medicaid program in American Samoa.

[2] Effective November 9, 1981, Arizona established the Health Care Cost Containment System, which provides health care to the poor based on a prepaid capitated basis. This system currently is a demonstration program supported by the Health Care Financing Administration.

State Medicaid programs. States can obtain SMI coverage for these "dual eligibles" under buy-in agreements with Medicare, whereby States pay the SMI premium and are responsible for Medicare cost sharing. Medicare makes the primary payment for Medicare services of dual eligibles and Medicaid pays the deductible and coinsurance. States receive Federal matching payments for these expenditures. States may buy into Medicare for any of their Medicaid-Medicare eligibles, but they receive Federal matching funds on premium payments only for persons receiving cash assistance (the categorically needy). States must pay the full cost of premium payments for other Medicaid eligibles.

If a State does not buy SMI coverage for Medicare-Medicaid eligibles, it cannot receive Federal matching payments for services that would have been covered under Medicare. Among States and jurisdictions with Medicaid programs (all States except Arizona), 46 States and jurisdictions had buy-in arrangements as of calendar year 1982; 4 States and 1 jurisdiction did not (Alaska, Louisiana, Oregon, Wyoming, and Puerto Rico).

Table 1.1

Medicare enrollees, persons served, and reimbursements in calendar year 1981 and Medicaid recipients and payments in fiscal year 1982, by area

Area[1]	Medicare		Medicaid recipients in thousands	Medicare reimbursements in millions	Medicaid payments in thousands	Medicare reimbursement per person served	Medicaid payment per recipient
	Enrollees in thousands[2]	Persons served					
All areas	29,009.9	18,881,282	[3] 21,603.2	$39,805,099	[3] $29,399.5	$2,108	[3] $1,361
United States	28,410.4	18,764,648	20,149.8	39,670,482	29,280.3	2,114	1,453
Alabama	500.9	317,772	321.8	641,364	338.1	2,018	1,051
Alaska	13.6	8,800	25.7	23,839	50.4	2,709	1,962
Arizona[4]	342.6	231,080	NA	445,685	NA	1,929	NA
Arkansas	352.6	228,535	196.4	393,348	266.6	1,721	1,357
California	2,684.9	1,920,182	3,747.9	4,764,649	3,536.5	2,481	944
Colorado	274.8	185,432	143.7	362,579	244.0	1,955	1,699
Connecticut	402.2	283,428	197.6	546,288	358.3	1,927	1,813
Delaware	68.1	47,210	48.2	86,170	55.8	1,825	1,157
District of Columbia	77.9	55,015	108.4	162,569	178.9	2,955	1,650
Florida	1,777.3	1,285,220	520.1	2,629,172	553.4	2,046	1,064
Georgia	601.3	388,362	437.7	707,654	569.6	1,822	1,301
Hawaii	85.3	56,610	102.1	103,394	125.0	1,826	1,225
Idaho	107.0	70,250	39.9	118,378	63.5	1,685	1,596
Illinois	1,372.1	826,590	1,063.4	2,230,080	1,344.4	2,698	1,264
Indiana	654.6	399,198	238.3	833,270	494.8	2,087	2,076
Iowa	421.0	257,252	179.6	474,092	287.3	1,843	1,560
Kansas	329.5	228,128	147.8	448,942	233.1	1,968	1,577
Kentucky	470.6	263,050	352.5	497,268	341.3	1,890	968
Louisiana	448.9	250,882	388.8	507,421	577.8	2,023	1,486
Maine	160.7	109,962	127.1	209,990	177.8	1,910	1,398
Maryland	433.3	291,245	323.2	705,907	417.7	2,424	1,292
Massachusetts	787.8	552,058	669.7	1,280,661	1,207.5	2,320	1,803
Michigan	1,055.1	760,492	1,174.8	1,793,937	1,292.6	2,359	1,100
Minnesota	522.5	339,548	323.3	680,791	795.5	2,005	2,461
Mississippi	330.1	203,642	303.6	352,018	262.9	1,729	866
Missouri	713.5	446,290	338.0	946,819	384.4	2,122	1,137
Montana	96.6	61,038	53.1	110,493	86.5	1,810	1,633
Nebraska	221.4	129,288	77.7	238,709	134.9	1,846	1,736
Nevada	78.2	50,945	28.7	131,642	65.4	2,584	2,288
New Hampshire	115.2	76,575	43.8	138,321	86.7	1,806	1,979
New Jersey	959.1	671,115	636.3	1,399,098	874.7	2,085	1,375
New Mexico	133.9	83,110	90.6	155,937	97.5	1,876	1,076
New York	2,374.6	1,695,058	2,145.1	3,541,064	5,585.9	2,089	2,604
North Carolina	699.3	426,128	353.8	750,946	482.8	1,762	1,365
North Dakota	88.7	60,325	31.1	116,843	65.9	1,937	2,120
Ohio	1,324.7	851,935	878.3	1,868,335	1,227.1	2,193	1,390
Oklahoma	406.4	248,972	242.7	484,333	361.6	1,945	1,490
Oregon	339.6	220,798	165.7	443,425	187.9	2,008	1,134
Pennsylvania	1,710.4	1,152,105	1,098.2	2,567,847	1,651.8	2,229	1,504
Rhode Island	140.5	109,288	123.9	207,090	201.0	1,895	1,622
South Carolina	339.8	207,278	250.1	347,563	278.9	1,677	1,115
South Dakota	99.8	58,245	35.7	107,983	76.9	1,854	2,160
Tennessee	588.7	352,050	363.0	669,369	464.3	1,901	1,279
Texas	1,485.0	909,568	676.3	1,827,853	1,157.5	2,010	1,712
Utah	121.7	76,398	59.6	124,107	97.9	1,624	1,643
Vermont	65.9	44,740	54.2	76,762	78.4	1,716	1,447
Virginia	572.9	361,958	319.0	696,842	472.6	1,925	1,481
Washington	482.2	326,798	253.1	541,991	425.9	1,658	1,683
West Virginia	279.1	161,478	178.3	302,406	121.0	1,873	679

See footnotes at end of table.

Table 1.1—Continued

Medicare enrollees, persons served, and reimbursements in calendar year 1981 and Medicaid recipients and payments in fiscal year 1982, by area

Area[1]	Medicare		Medicaid recipients in thousands	Medicare reimbursements in millions	Medicaid payments in thousands	Medicare reimbursement per person served	Medicaid payment per recipient
	Enrollees in thousands[2]	Persons served					
Wisconsin	629.0	397,588	459.8	822,059	820.9	2,068	1,785
Wyoming	41.6	24,300	12.2	45,966	18.9	1,892	1,552
State unknown	27.7	1,338	NA	7,210	NA	5,389	NA
U. S. territories and possessions[5]	371.8	113,434	1,453.5	122,188	119.2	1,077	82
Guam	2.3	478	—	1,320	—	2,762	—
Puerto Rico	363.5	108,592	1,437.7	117,365	116.0	1,081	81
Virgin Islands	5.1	1,848	15.8	2,863	3.2	1,549	203
Foreign countries	227.8	5,560	NA	12,430	NA	2,236	NA

[1] For Medicare, area of enrollee; for Medicaid, area of provider of medical services.
[2] As of July 1, 1981.
[3] For fiscal year 1981: recipients, 22.0 million; payments, $27.2 billion; and payment per recipient, $1,238.
[4] Arizona does not have a Medicaid program.
[5] Includes all other outlying areas.

NOTE: Medicare data are for services rendered during calendar year 1981; Medicaid data are for services paid for during fiscal year 1982.

SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981*. HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Unpublished data.

State Medicaid programs also provide many services for the aged and disabled that are not provided by Medicare, including skilled nursing facility care beyond Medicare's 100-day posthospital benefit, long-term care in intermediate care facilities, prescription drugs, eyeglasses, and hearing aids. In terms of the range of benefits that a State may provide, Medicaid is more comprehensive than Medicare.

Medicaid also has a more pronounced long-term care orientation. There are no Federal limits on the length-of-stay in nursing homes that can be covered by Medicaid. Additionally, the law allows States to cover intermediate care facilities, but Medicare does not. In 1982, 43.8 percent of Medicaid program expenditures were for long-term care services.

Medicare enrollees and persons served, Medicaid recipients, and program expenditures

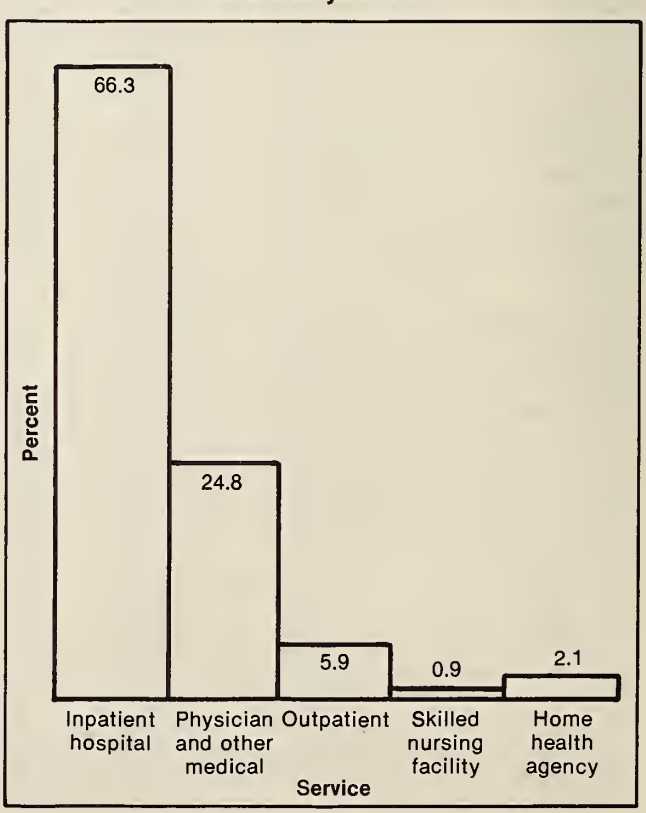
Medicare and Medicaid population data and expenditures are compared in Table 1.1. In calendar year (CY) 1981, 18.9 million (65.1 percent) of the 29.0 million aged and disabled persons enrolled in Medicare received Medicare reimbursements. In fiscal year (FY) 1981, 22.0 million persons received health services paid by Medicaid, and in FY 1982, 21.6 million persons received such services.[3] Twenty-six percent of all persons served under the Medicare program lived in California, New York, or Florida. For Medicaid, the three States with the largest number of recipients in FY 1982 were California, New York, and Michigan, which together accounted for 32.7 percent of all Medicaid recipients.

In CY 1981, Medicare spent $39.8 billion. In FY 1981, $27.2 billion were spent on behalf of Medicaid recipients, and $29.4 billion were spent in FY 1982. Medicare reimbursements for California residents in CY 1981 ($4.8 billion) were larger than in any other State. Reimbursements for residents of New York ($3.5 billion),

[3] No reliable national estimates of the total number of persons enrolled in Medicaid at any one time or over a period of time before April 1980 are available.

Figure 1.1

Percent distribution of Medicare reimbursements, by type of service: Calendar year 1981



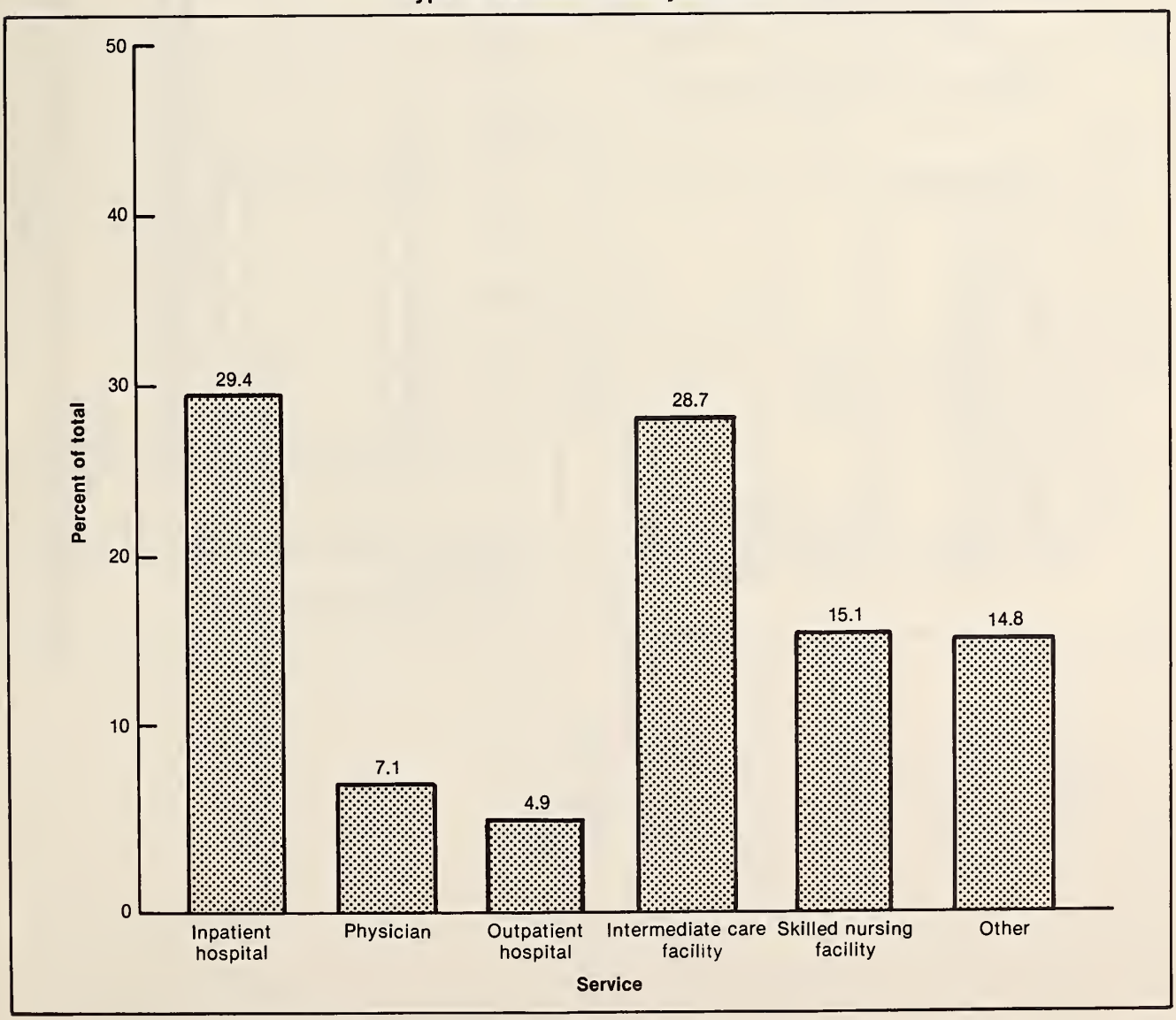
Florida ($2.6 billion), and Pennsylvania ($2.6 billion) were next in size. Together, these four States accounted for 34 percent of total Medicare reimbursements. Payments for Medicaid recipients in FY 1982 were largest in New York ($5.6 billion), California ($3.5 billion), Pennsylvania ($1.7 billion), Illinois ($1.3 billion), and Michigan ($1.3 billion). These five States accounted for 45.6 percent of total Medicaid expenditures.

The average Medicare reimbursement per person served was $2,108 in CY 1981. The average payment per Medicaid recipient was $1,238 in FY 1981 and $1,361 in FY 1982. Medicare enrollees in the District of Columbia had the largest reimbursement per person served ($2,955) with total reimbursements of $163 million. Next in size were Alaska ($2,709) with total reimbursements of $24 million and Illinois ($2,698) with total reimbursements of $2,230 million. Payments per Medicaid recipient in FY 1982 were highest in New York ($2,604) with total payments of $5,585.9 million, Minnesota ($2,461) with total payments of $795.5 million, and Nevada ($2,288) with total payments of $65.4 million.

Figures 1.1 through 1.4 illustrate several important differences between Medicare and Medicaid. Consistent with its statute, Medicare is oriented toward acute care services, as shown in Figure 1.1. Inpatient hospital care accounts for nearly two-thirds of total Medicare reimbursements (HI and SMI combined). Less than 1 percent of Medicare reimbursements go to SNF's, with coverage limited to short-term posthospital recuperative or rehabilitative care. In contrast, as shown in Figure 1.2, inpatient hospital services absorb only 29.4 percent of total Medicaid payments, with payments for long-term care in nursing homes (both intermediate care facilities and SNF's) making up 43.8 percent of the total.

Medicare and Medicaid also differ in the relative size and distribution of reimbursements among the groups served, as Figures 1.3 and 1.4 show. Medicare predominantly serves the aged, who comprise 90 percent of all

Figure 1.2
Percent distribution of Medicaid payments, by type of service: Fiscal year 1982



enrollees and receive 87 percent of all reimbursements. The aged and disabled make up 28 percent of all Medicaid recipients but account for 71 percent of all payments. In contrast, children and adults eligible through the AFDC category make up 69 percent of all recipients but account for only 26 percent of total payments.

Administration of Medicare and Medicaid

Medicare and Medicaid were administered by separate agencies in the Department of Health, Education, and Welfare from 1965 to 1977. In 1977, these agencies were merged into the Health Care Financing Administration within the Department of Health and Human Services. Under the new structure, the operation of Medicare and Medicaid is combined, with each newly created bureau or office dealing with a specific aspect of both programs. These changes were designed to reduce duplication of effort and enhance consistency and coordination of Medicare and Medicaid. An intermediate level of associate administrators was added in 1981.

As shown in Figure 1.5, four senior officials now report to the Administrator and Deputy Administrator on the following phases of HCFA operations.

- Operations.
- Policy.
- Management and Support Services.
- External Affairs.

Figure 1.3

Percent distribution of Medicare enrollment and reimbursement, by type of enrollee: Calendar year 1981

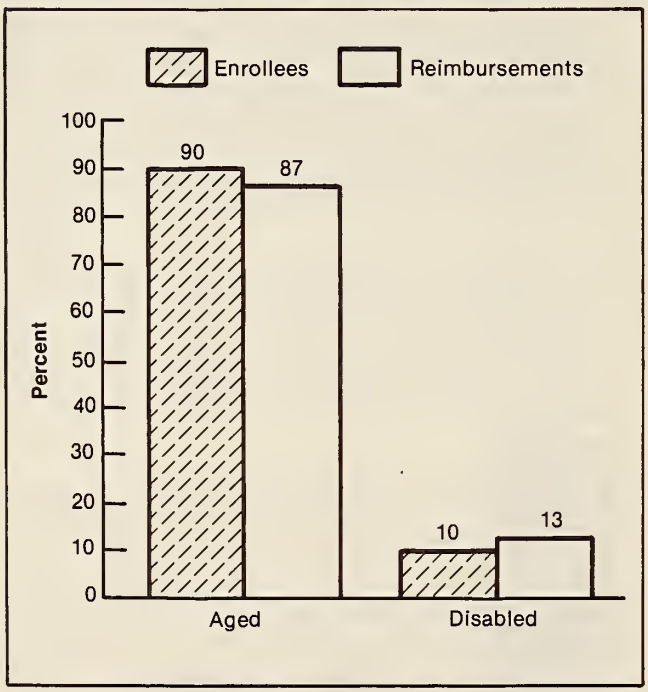
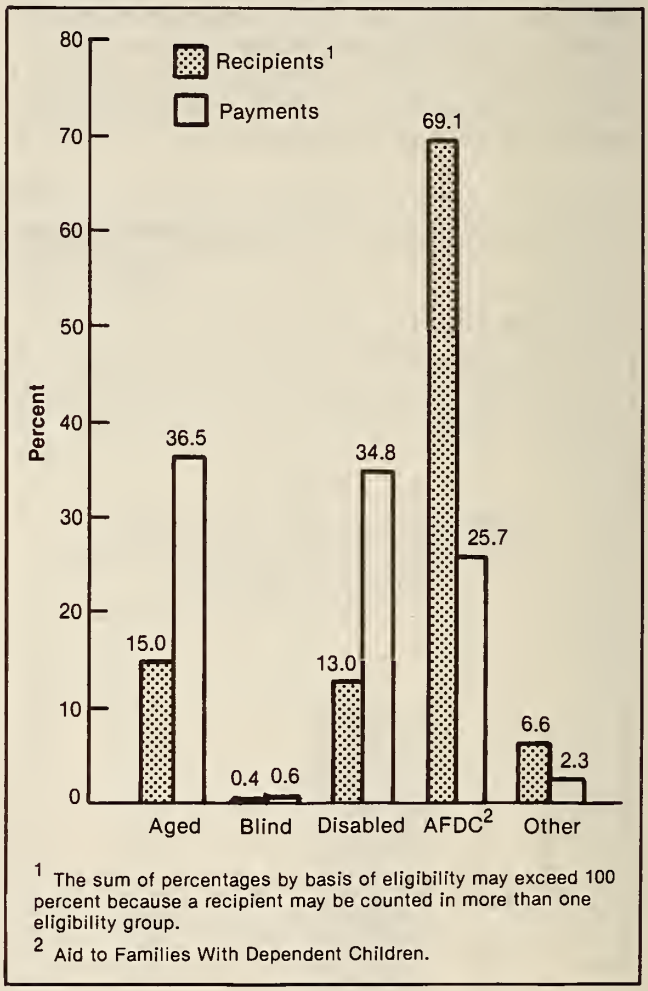


Figure 1.4

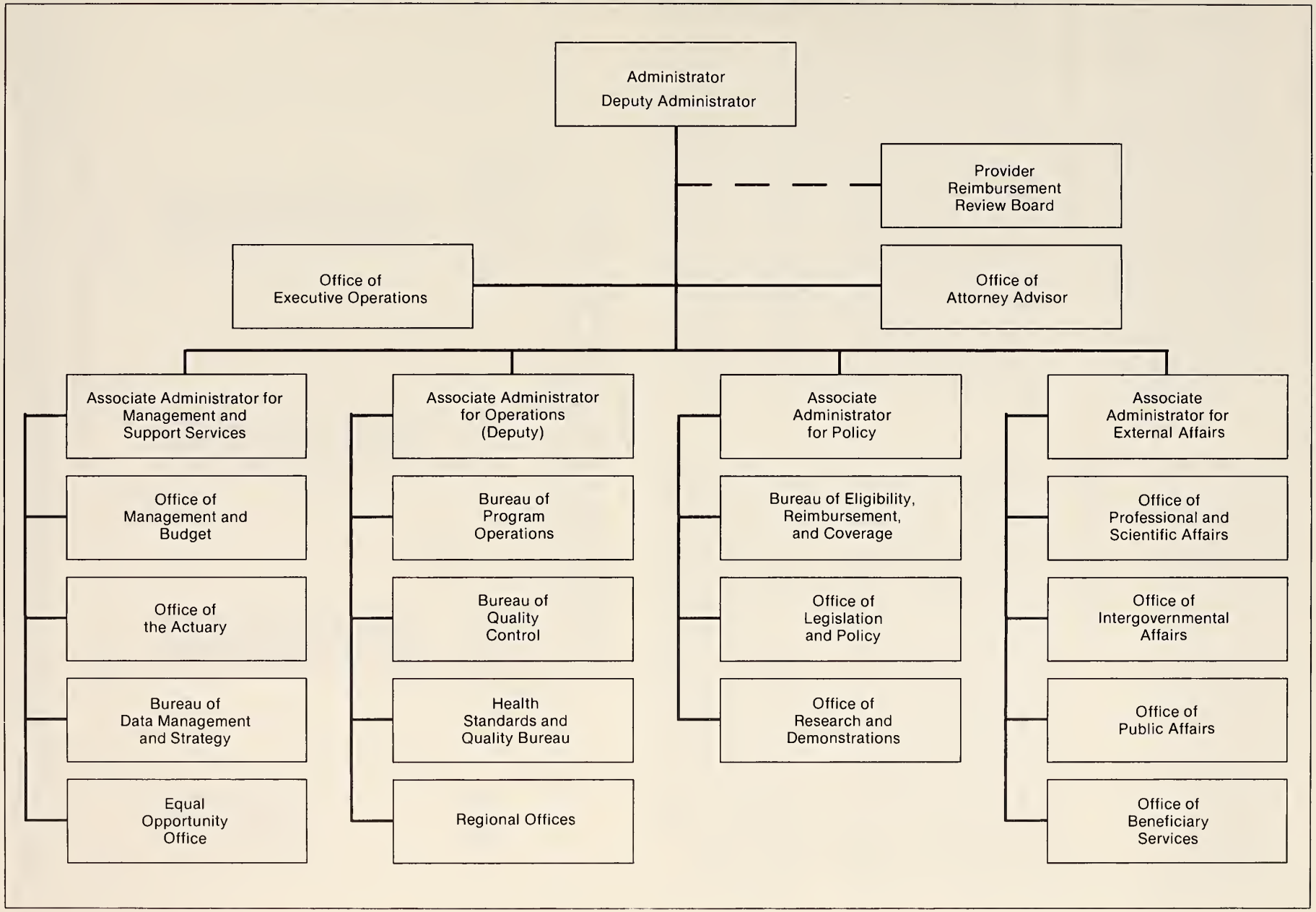
Percent distribution of Medicaid recipients and payments, by basis of eligibility: Fiscal year 1982



[1] The sum of percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.

[2] Aid to Families With Dependent Children.

Figure 1.5
Health Care Financing Administration organization chart, March 1985


Administrator
Deputy Administrator
Provider Reimbursement Review Board
Office of Executive Operations
Office of Attorney Advisor
Associate Administrator for Management and Support Services
Office of Management and Budget
Office of the Actuary
Bureau of Data Management and Strategy
Equal Opportunity Office
Associate Administrator for Operations (Deputy)
Bureau of Program Operations
Bureau of Quality Control
Health Standards and Quality Bureau
Regional Offices
Associate Administrator for Policy
Bureau of Eligibility, Reimbursement, and Coverage
Office of Legislation and Policy
Office of Research and Demonstrations
Associate Administrator for External Affairs
Office of Professional and Scientific Affairs
Office of Intergovernmental Affairs
Office of Public Affairs
Office of Beneficiary Services

2. Medicare and Medicaid trends

This chapter reports trends in the Medicare and Medicaid programs: the number of Medicare enrollees and Medicaid recipients, by basis of eligibility and population characteristics; expenditures, in total and by eligibility category; and hospital inpatient services, physicians' services, and other selected services financed by the Medicare and Medicaid programs. The evolution of the Medicare and Medicaid programs is also analyzed.

Enrollees and recipients

Table 2.1 shows that from 1966 through 1981, the number of Medicare enrollees increased 2.8 percent per year. (The annual compound rate of growth, ACRG, which is expressed as a percent, is shown in the tables.) Supplementary medical insurance (SMI) enrollment increased slightly faster than hospital insurance (HI) enrollment. Total enrollment jumped over 10 percent from 1972 to 1973, reflecting the extension of Medicare coverage to the disabled by the 1972 amendments to the Social Security Act. Earlier, only persons 65 years of age or over were covered by Medicare.

From 1973 to 1982, the number of Medicaid recipients (persons who actually received services paid for by Medicaid) increased 1.1 percent a year.[4] This upward trend included periods of growth and decline (Figure 2.1). The number of Medicaid recipients increased through 1977, then declined through 1979, rose slightly during the period 1980-81, and declined again in 1982. In contrast, Medicare enrollment grew continuously from 1966 through 1981.

[4]The Medicaid data presented in this report were first compiled in the present format in FY 1973. Previous data were based on reporting categories different from those now used. To avoid erroneous inferences, data for earlier years are excluded from this report.

Medicare enrollees

Table 2.2 presents data on the number of aged HI and SMI enrollees by age, sex, and race for calendar years (CY) 1966-81. All demographic groups shown in the table grew in size, with SMI enrollment increasing faster than HI enrollment in each group. For both HI and SMI, women, persons other than white, and persons 75 years of age or over had greater enrollment increases than other groups. The gradual aging of Medicare enrollees has long-term consequences for the Medicare program. Older enrollees are relatively high users of health care services and raise the average reimbursement per enrollee.

The rate of growth in the number of disabled enrollees during CY 1973-81 (Table 2.3) was much greater than that of aged enrollees (Table 2.2). For both HI and SMI, the greatest increase in enrollment among the disabled occurred within the youngest age group. HI and SMI enrollment showed smaller increases for males than females and for white enrollees than for all others.

Table 2.1

Number of Medicare enrollees by type of coverage and number of Medicaid recipients: 1966-82

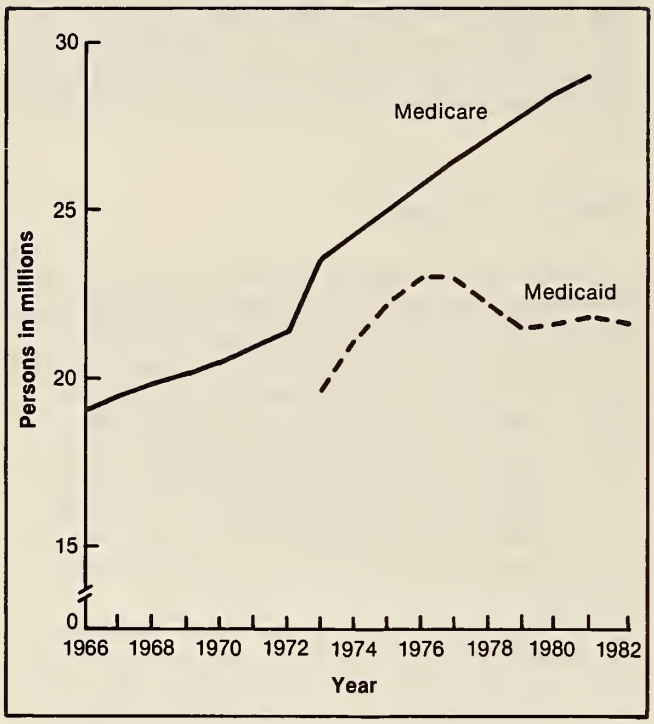
Year[1]	Medicare enrollees			Medicaid recipients
	Hospital insurance and/or supplementary medical insurance	Hospital insurance	Supplementary medical insurance	
	Number in thousands			
1966	19,108.8	19,082.5	17,736.0	—
1967	19,521.0	19,493.9	17,893.0	—
1968	19,821.0	19,769.7	18,804.8	—
1969	20,102.7	20,014.2	19,194.7	—
1970	20,490.9	20,361.2	19,584.4	—
1971	20,914.9	20,742.3	19,974.7	—
1972	21,332.1	21,115.3	20,351.3	—
1973	23,545.4	23,301.1	22,490.5	19,622.2
1974	24,201.0	23,924.1	23,166.6	21,116.0
1975	24,958.6	24,640.5	23,904.6	22,222.7
1976	25,662.9	25,312.6	24,614.4	22,890.9
1977	26,457.9	26,093.9	25,363.5	22,920.5
1978	27,164.2	26,777.3	26,074.1	22,197.9
1979	27,858.7	27,459.2	26,757.3	21,540.0
1980	28,478.2	28,066.9	27,399.7	21,604.4
1981	29,010.0	28,589.5	27,941.2	21,979.6
1982	—	—	—	21,603.2
	Percent			
ACRG[2]	2.8	2.7	3.1	1.1

[1] Medicare data are for July 1 of each calendar year; Medicaid data are for each fiscal year.
[2] Annual compound rate of growth.

SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Unpublished data.

Figure 2.1

Number of Medicare enrollees and Medicaid recipients: 1966-82



Medicaid recipients

Table 2.4 presents trend data on the number of Medicaid recipients by basis of eligibility and maintenance assistance status. Recipients are divided into two assistance groups: (1) those who receive cash payments as well as Medicaid benefits and (2) those who receive medical assistance only.[5]

During the period 1973-82, the total number of cash assistance recipients using Medicaid services increased at an average rate of 1.5 percent a year. The number of Medicaid recipients in the aged and blind cash assistance groups decreased during the same period at an annual rate of 2.0 and 1.5 percent per year, respectively. Of all cash assistance groups, the highest rate of growth in the number of Medicaid recipients occurred among disabled enrollees. Most of this increase occurred from 1973 to 1977, when the total number of disabled cash recipients increased by more than half. The number of children under age 21, who comprise 49 percent of all cash assistance Medicaid recipients, grew at an annual rate of 1.7 percent per year.

The number of Medicaid recipients not receiving cash assistance increased at a slightly slower rate than the cash assistance group, 1.1 percent per year. Among recipients of medical assistance only, the numbers of disabled and AFDC-related adult recipients grew most rapidly, at rates of 5.5 and 9.1 percent per year, respectively. The number of children under 21 who received "medical

[5]Data on medically needy recipients, a subgroup of recipients receiving medical assistance only, is available on request from the Bureau of Data Management and Strategy for FY 1975 and later years.

Table 2.2

Number of aged Medicare enrollees, by type of coverage, age, sex, and race: July 1, 1966-81

	Hospital insurance							Supplementary medical insurance						
		Age		Sex		Race[1]			Age		Sex		Race[1]	
Year	Total	65-74 years	75 years or over	Male	Female	White	All other	Total	65-74 years	75 years or over	Male	Female	White	All other
	Number in thousands													
1966	19,082	11,990	7,092	8,133	10,950	17,042	1,445	17,736	11,186	6,550	7,534	10,202	15,938	1,264
1967	19,494	12,116	7,378	8,243	11,251	17,385	1,496	17,893	11,114	6,779	7,547	10,346	16,124	1,245
1968	17,770	12,158	7,611	8,318	11,452	17,632	1,525	18,805	11,561	7,244	7,878	10,927	16,877	1,368
1969	20,014	12,195	7,819	8,396	11,618	17,859	1,558	19,195	11,705	7,490	8,010	11,185	17,229	1,406
1970	20,361	12,316	8,045	8,507	11,855	18,187	1,608	19,584	11,873	7,711	8,132	11,452	17,576	1,472
1971	20,742	12,462	8,280	8,628	12,114	18,582	1,672	19,975	12,050	7,924	8,250	11,724	17,974	1,532
1972	21,115	12,641	8,474	8,744	12,371	18,930	1,693	20,351	12,248	8,104	8,360	11,991	18,325	1,557
1973	21,571	12,911	8,660	8,911	12,660	19,242	1,762	20,921	12,586	8,334	8,569	12,352	18,737	1,636
1974	21,996	13,182	8,814	9,005	12,991	19,601	1,809	21,422	12,925	8,496	8,694	12,727	19,149	1,704
1975	22,472	13,426	9,046	9,168	13,304	19,996	1,870	21,945	13,215	8,730	8,873	13,073	19,575	1,781
1976	22,920	13,691	9,229	9,324	13,596	20,382	1,916	22,446	13,529	8,917	9,047	13,399	19,995	1,845
1977	23,475	13,986	9,488	9,537	13,937	20,857	1,977	22,991	13,830	9,161	9,240	13,751	20,456	1,909
1978	23,984	14,259	9,725	9,728	14,256	21,289	2,036	23,531	14,119	9,412	9,436	14,094	20,904	1,978
1979	24,584	14,582	9,967	9,945	14,604	21,770	2,100	24,098	14,414	9,685	9,645	14,454	21,385	2,046
1980	25,104	14,894	10,210	10,156	14,948	22,244	2,160	24,680	14,726	9,954	9,868	14,813	21,876	2,114
1981	25,591	15,152	10,439	10,340	15,250	22,661	2,210	25,182	14,977	10,205	10,055	15,127	22,298	2,172
	Percent													
ACRG[2]	2.0	1.6	2.6	1.6	2.2	1.9	2.9	2.4	2.0	3.0	1.9	2.7	2.3	3.7

[1] Excludes unknown race.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 2.3

Number of disabled Medicare enrollees, by type of coverage, age, sex, and race: July 1, 1973-81

Year	Hospital insurance									Supplementary medical insurance								
		Age				Sex		Race[1]			Age				Sex		Race[1]	
	Total	Under 35 years	35-44 years	45-54 years	55-64 years	Male	Female	White	All other	Total	Under 35 years	35-44 years	45-54 years	55-64 years	Male	Female	White	All other
	Number in thousands																	
1973	1,730.5	192.4	218.0	438.8	881.4	1,118.8	611.8	1,444.9	253.2	1,569.9	174.9	194.7	390.2	810.0	1,003.3	566.6	1,307.7	233.4
1974	1,928.1	220.2	237.6	481.4	988.9	1,232.1	696.0	1,602.3	287.1	1,745.0	194.0	211.0	428.0	912.0	1,102.0	643.0	1,446.0	263.1
1975	2,168.4	254.3	261.7	530.0	1,122.4	1,380.9	787.5	1,800.9	329.2	1,959.2	225.8	232.3	469.2	1,032.0	1,230.6	728.7	1,622.3	300.3
1976	2,392.2	288.3	285.8	574.0	1,244.1	1,514.3	877.8	1,983.2	370.9	2,168.5	258.3	255.7	510.2	1,144.3	1,352.8	815.7	1,792.6	339.6
1977	2,619.4	322.6	310.6	617.3	1,368.9	1,654.2	965.2	2,163.0	415.1	2,372.6	290.0	278.8	548.7	1,255.2	1,475.4	897.3	1,954.3	379.3
1978	2,793.2	344.8	335.4	646.5	1,466.5	1,763.0	1,030.2	2,299.1	447.8	2,543.2	311.9	303.1	579.2	1,349.0	1,581.8	961.3	2,088.9	411.0
1979	2,910.8	361.4	356.0	658.0	1,535.3	1,837.4	1,073.4	2,388.1	471.4	2,658.8	328.6	323.4	592.6	1,414.3	1,655.1	1,003.7	2,176.7	433.9
1980	2,963.2	371.2	369.5	657.5	1,565.0	1,870.5	1,092.6	2,422.2	486.7	2,719.2	339.7	337.1	596.3	1,446.1	1,694.6	1,024.7	2,218.2	449.8
1981	2,999.0	383.5	385.1	654.7	1,575.6	1,896.0	1,102.9	2,442.1	499.9	2,759.5	352.7	352.3	596.3	1,458.2	1,723.9	1,035.6	2,242.3	463.5
	Percent																	
ACRG[2]	7.1	9.0	7.4	5.1	7.5	6.8	7.6	6.8	8.9	7.3	9.2	7.7	5.4	7.6	7.0	7.8	7.0	9.0

[1] Excludes unknown race.
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

assistance only'' services decreased by an annual compound rate of growth of 1.9 percent.

Table 2.5 presents data for FY 1973-82 on the age, sex, and race of Medicaid recipients. Some data were estimated for reporting States. The race of significant numbers of recipients in some reporting States was unknown, so race data should be used with caution. The number of recipients in the group 65 years or over decreased at an annual rate of 2.0 percent. All other age groups grew at rates ranging from 1.2 to 3.7 percent per year.

Expenditures

Table 2.6 and Figure 2.2 present data on Medicare reimbursements and Medicaid payments. Total Medicare reimbursements grew at an average annual rate of 17.5 percent from 1967 to 1981. SMI reimbursements increased more rapidly than HI reimbursements. The large increase in total reimbursements from 1973 to 1974, 29.6 percent, is a result of the extension of Medicare coverage to the disabled.

The entry of the disabled also accelerated the rate of

Table 2.4

Number of Medicaid recipients, by maintenance assistance status and basis of eligibility: Fiscal years 1973-82

	Cash assistance							Medical assistance only						
		SSI[1]			AFDC[2]				SSI[1]			AFDC[2]		
Year	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX[4]	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX
							Number in thousands							
1973	14,519.9	2,226.9	83.6	1,425.4	7,017.3	3,616.7	150.0	5,102.3	1,268.6	17.7	378.7	1,641.4	449.7	1,346.2
1974	15,969.1	2,510.3	99.9	1,810.8	7,693.9	3,727.8	126.3	5,147.3	1,191.4	29.2	386.8	1,652.2	562.9	1,324.9
1975	16,805.0	2,443.6	84.9	1,830.3	8,393.3	4,052.9	NA	5,417.7	1,215.8	23.7	449.9	1,286.8	577.1	1,864.4
1976	17,201.0	2,408.3	76.7	1,984.8	8,512.0	4,219.3	NA	5,689.9	1,236.2	17.5	512.2	1,427.1	591.0	1,905.9
1977	17,103.4	2,408.7	76.1	2,178.1	8,361.8	4,078.5	NA	5,817.1	1,149.7	9.8	519.4	1,366.6	737.6	2,034.1
1978	16,622.6	2,194.0	64.9	2,101.4	8,247.7	4,014.6	NA	5,575.3	1,184.5	9.8	535.7	1,252.3	688.0	1,905.0
1979	15,964.8	2,070.9	66.7	2,028.0	7,923.8	3,875.3	NA	5,575.3	1,283.2	13.5	633.2	1,219.1	678.1	1,748.2
1980	16,312.5	2,046.8	76.6	2,123.7	8,003.8	4,007.3	NA	5,511.5	1,369.6	15.7	618.8	1,278.7	726.2	1,507.4
1981	16,871.8	1,952.6	71.1	2,254.9	8,305.9	4,327.5	NA	5,492.9	1,414.0	15.3	737.8	1,274.8	859.7	1,364.3
1982	16,594.1	1,850.7	72.7	2,190.6	8,187.0	4,370.1	NA	5,642.5	1,389.0	11.6	615.7	1,376.5	986.2	1,433.7
							Percent							
ACRG[5]	1.5	-2.0	-1.5	4.9	1.7	2.1	NA	1.1	1.0	-4.6	5.5	-1.9	9.1	.7

[1] Supplemental Security Income.
[2] Aid to Families With Dependent Children.
[3] Totals for each year include estimated recipient counts for nonreporting States. The sum of recipients in the maintenance assistance categories exceeds total recipients because recipients who are eligible in more than one category are counted in each category but only once in the total.
[4] Cash assistance to other Title XIX recipients was phased out after 1974.
[5] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Table 2.5

Number of Medicaid recipients, by age, sex, and race: Fiscal years 1973-82

		Age				Sex		Race		
Year	Total	Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	All other	Unknown
					Number in thousands					
1973	19,622.2	2,890.4	5,943.6	6,292.8	4,495.4	7,222.9	12,399.3	—	—	—
1974	21,116.4	3,410.3	6,717.1	7,304.2	3,684.8	7,342.2	13,774.2	—	—	—
1975	22,222.7	3,366.7	7,329.0	7,735.7	3,791.2	7,762.4	14,460.3	8,315.5	6,165.9	7,741.3
1976	22,890.9	3,596.2	7,732.5	7,869.9	3,692.3	8,000.4	14,890.5	8,383.3	6,620.3	7,887.3
1977	22,920.5	3,504.5	7,359.8	8,267.4	3,788.8	8,065.7	14,854.8	8,471.9	6,421.3	8,027.3
1978	22,197.9	3,438.5	7,241.0	7,957.9	3,560.5	7,720.4	14,477.5	8,207.7	6,313.3	7,676.9
1979	21,540.0	3,401.2	6,856.2	7,511.0	3,771.7	7,474.4	14,065.6	8,043.5	7,125.9	6,370.6
1980	21,604.4	4,017.5	6,906.3	7,350.0	3,330.5	7,702.3	13,902.1	7,846.6	6,275.9	7,481.8
1981	21,979.6	4,088.2	6,945.5	7,121.4	3,824.4	7,912.6	14,066.9	10,198.5	5,494.9	6,286.2
1982	21,603.2	4,018.2	6,826.6	6,999.4	3,758.9	7,777.1	13,826.1	10,023.9	5,400.8	6,178.5
					Percent					
ACRG[1]	1.1	3.7	1.6	1.2	−2.0	.8	1.2	2.7	−1.9	−3.2

[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

increase in SMI reimbursements, largely because of the rising number of end-stage renal dialysis (ESRD) patients. Charges for renal dialysis have generally been held to a maximum of $138 per treatment ($110 in reimbursements). Thus, the accelerating rate of SMI reimbursements among the disabled reflects increases in the number of ESRD patients rather than increases in reimbursements per patient. ESRD users generally require three treatments a week, so a regular schedule of dialysis at $138 per treatment costs about $22,000 a year for the average user ($17,000 in reimbursements).

Medicaid payments also increased throughout the period covered growing at an average annual rate of 14.6 percent. Payments for the aged, blind, and disabled grew the fastest. As indicated in Figure 2.2, annual percentage increases in Medicare reimbursements have historically been higher than those for Medicaid payments.

Figures 2.3 and 2.4 show changes over time in the distribution of Medicare reimbursements and Medicaid payments by type of service covered. The proportion of total Medicaid payments that went for inpatient hospital services decreased from 30.8 percent in 1973 to 29.4 percent in 1982. Conversely, the proportion of Medicare reimbursements for inpatient hospital services increased slightly, from 62.7 percent in 1967 to 66.3 percent in 1981. A small decrease occurred over the same period in the proportion of all Medicare reimbursements made for physicians and other medical services, from 28.9 percent in 1967 to 24.8 percent in 1981. Physician payments as a proportion of total Medicaid payments also decreased, from 10.7 percent in 1973 to 7.1 percent in 1982.

Reimbursements for outpatient services as a proportion of all Medicare reimbursements increased sixfold from 1967 to 1981, from .9 percent to 5.9 percent. In part, this increase is attributable to use of renal dialyses by ESRD patients. Medicaid payments for outpatient services increased at a much slower rate, from 3.1 percent in 1973 to 4.9 percent in 1982. Medicare reimbursements for home health agency services, increased from 1.0 percent in 1967 to 2.1 percent in 1981.

The proportion of Medicare reimbursements for skilled nursing facility services decreased markedly from 1967 (6.5 percent) to 1981 (.9 percent). In contrast, Medicaid payments for skilled nursing facility and intermediate care facility services increased from 34.9 percent in 1973 to 43.8 percent in 1982. As these charts show, long-term care services accounted for the largest proportion of total Medicaid payments, and acute care services were responsible for the largest share of total Medicare reimbursements.

Table 2.6

Medicare reimbursements by type of coverage, Medicaid payments by basis of eligibility, and percent change in total from previous year: 1966-82

	Medicare reimbursements				Medicaid payments				
		Coverage				Basis of eligibility			
Year[1]	Total	Hospital insurance	Supplementary medical insurance	Percent	Total	AFDC[2]	SSI and AABD[3]	Other	Percent
	Amount in millions				Amount in millions				
1966[4]	$1,019	$891	$128	NA	—	—	—	—	—
1967	4,549	3,353	1,197	446.5	—	—	—	—	—
1968	5,697	4,179	1,518	25.2	—	—	—	—	—
1969	6,603	4,739	1,865	15.9	—	—	—	—	—
1970	7,099	5,124	1,975	7.5	—	—	—	—	—
1971	7,868	5,751	2,117	10.8	—	—	—	—	—
1972	8,643	6,318	2,325	9.9	—	—	—	—	—
1973[5]	9,583	7,057	2,526	10.9	$8,640	$2,872	$5,315	$452	NA
1974	12,418	9,099	3,318	30.2	9,983	5,093	6,159	425	15.5
1975	15,588	11,315	4,273	24.9	12,292	4,063	7,606	623	23.1
1976	18,420	13,340	5,080	18.2	14,135	4,598	8,827	710	15.0
1977	21,774	15,737	6,038	18.2	16,277	4,978	10,378	909	15.2
1978	24,934	17,682	7,252	14.5	17,966	5,343	11,646	974	10.4
1979	29,331	20,623	8,708	17.6	20,474	5,700	13,879	900	14.0
1980	35,699	25,064	10,635	21.7	23,301	6,543	15,845	914	13.8
1981	43,455	30,342	13,113	21.7	27,204	7,271	19,381	552	16.7
1982	—	—	—	—	29,399	7,567	21,144	689	8.1
				Percent					
ACRG[6]	[7] 17.5	[7] 17.0	[7] 18.6	NA	14.6	11.4	16.6	4.8	NA

[1] Medicare data are for calendar years; Medicaid data are for fiscal years.
[2] Aid to Families With Dependent Children.
[3] Supplemental Security Income and Aid to the Aged, Blind, and Disabled.
[4] July-December only.
[5] Disabled enrollees were covered by Medicare on July 1, 1973.
[6] Annual compound rate of growth.
[7] ACRG computed for 1967-81 only.

SOURCES: Medicare statistics: Board of Trustees, Federal Hospital Insurance Trust Fund: *1982 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, Apr. 5, 1982; Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1982 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, Apr. 5, 1982. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Figure 2.2

Medicare reimbursements and Medicaid payments: 1966-82

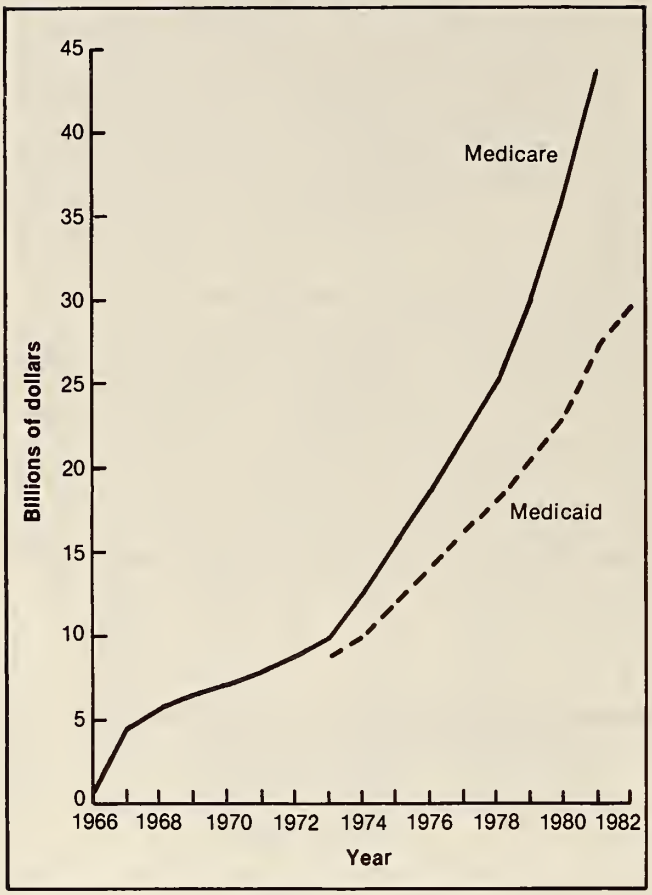
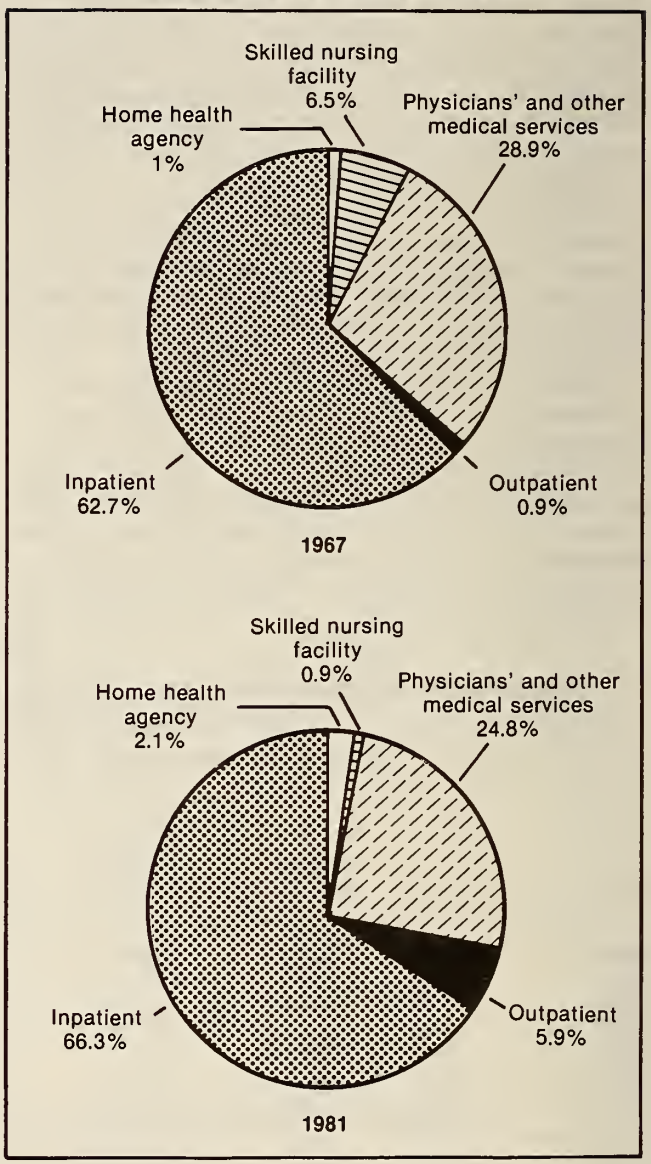


Figure 2.3

Percent distribution of Medicare reimbursements, by type of service: Calendar years 1967 and 1981



Medicare reimbursements

Trend data on Medicare reimbursements by type of coverage and type of enrollee are provided in Table 2.7. Successive increases in reimbursements for each entitlement group resulted in a more than sevenfold increase in total reimbursements during the period 1968-81. A portion of this increase is, of course, due to the extension of Medicare coverage to disabled persons in 1973. Reimbursements for the disabled grew much faster than reimbursements for the aged, increasing to 13.3 percent of total reimbursements in 1981 from 8.7 percent in 1974.

Figure 2.5 shows that a very small proportion of enrollees with high medical expenses accounted for a very large proportion of reimbursements for both aged and disabled enrollees. Among the aged, those reimbursed $15,000 or more represented only 1.4 percent of all aged enrollees but accounted for 25.5 percent of all Medicare reimbursements for the aged in 1981. At the other extreme, 38.0 percent of aged enrollees received no reimbursements during the year (either because they had no covered Medicare charges, they did not exceed Medicare deductibles, their bills exceeded the deductibles but they did not file a claim, or they received covered services without charge). Another 41.1 percent of aged enrollees received less than $1,000 in reimbursements.

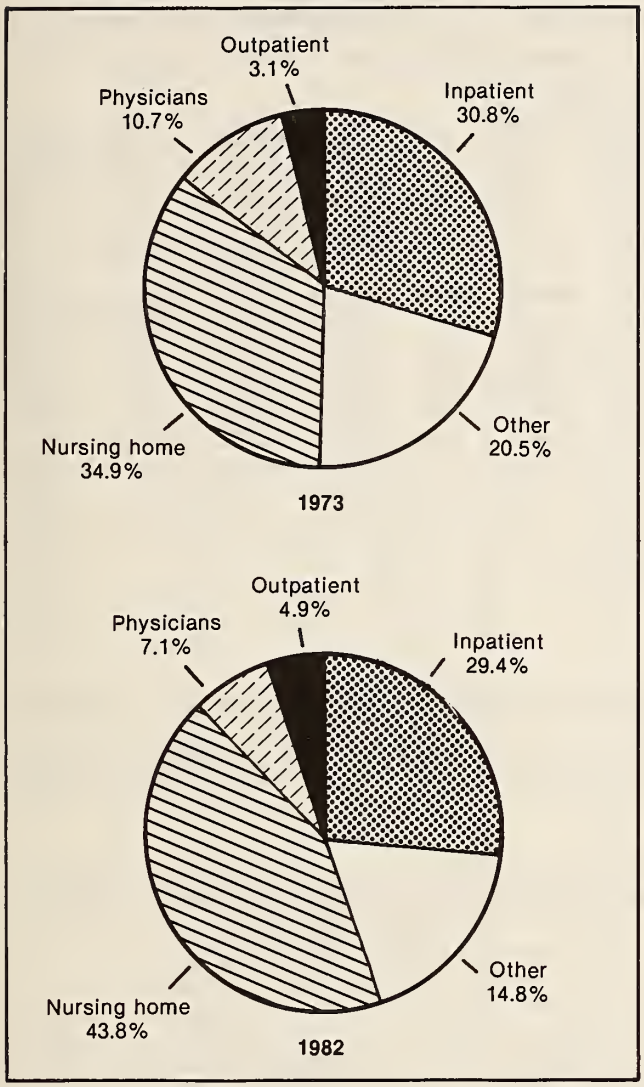
Comparable figures for the disabled show even more graphically that health insurance spreads the risk of illness. Although representing only 2.7 percent of all disabled enrollees, those in the group reimbursed $15,000 or more accounted for 42.3 percent of all reimbursements for disabled enrollees. The significantly greater proportion of ESRD patients among disabled enrollees is one reason that "high-cost" users account for a larger share of reimbursements in this group than in the aged group.

Medicaid payments

As shown in Table 2.8, Medicaid payments grew the fastest for services provided to the disabled in both maintenance assistance groups. The slowest rate of increase occurred for children under 21 years of age not receiving cash assistance. In sharp contrast, a relatively rapid

Figure 2.4

Percent distribution of Medicaid payments, by type of service: Fiscal years 1973 and 1982



growth occurred in payments for children receiving cash assistance. As shown in Table 2.4, the number of children not receiving cash assistance declined by 16 percent over the period 1973-82.

Trends in Medicaid payments for long-term care, inpatient hospital services and all other Medicaid services are shown in Figure 2.6 (Muse, 1982). Payments for long-term care services have increased steadily since FY 1973. Inpatient hospital services and the remaining Medicaid services also increased, but less rapidly. Payments for physician and clinic services each increased $1.2 billion from FY 1973 to FY 1982. However, as a percent of total payments, payments for physician services decreased 3.6 percentage points and outpatient payments increased by 1.8 percentage points over the same period. Similarly, payments for prescribed drugs grew $1.0 billion over the period, but decreased 1.6 percentage points as a proportion of total payments.

Table 2.9 reports Medicaid expenditures by age, sex, and race of recipients. Variations in the growth of expenditures by age range from 14.0 percent for persons 21-64 years to 17.0 percent for children under 6 years of age. Payments on behalf of male recipients grew at the same rate as payments for female recipients, 14.6 percent. As in Table 2.5, recipients' race was not reported by some States.

As with Medicare, a small number of recipients consume a disproportionate share of Medicaid payments. Figure 2.7 shows the share of total recipients and total payments accounted for by each of five eligibility groups. In FY 1982, the aged accounted for 15 percent of all recipients but more than 36 percent of all payments. Similarly, the blind and disabled accounted for only 13.4 percent of all recipients but 35.4 percent of all payments. Together, these groups accounted for 28.4 percent of all recipients and 71.9 percent of all payments. At the opposite end of the spectrum are children in Aid to Families With Dependent Children (AFDC) families, who accounted for 44.3 percent of all recipients but only 11.8 percent of all payments.

Short-stay hospital and physicians' services

Data on Medicare and Medicaid short-stay inpatient hospital use, including discharges, covered days of care, reimbursements for Medicare enrollees, and payments for Medicaid recipients, are shown in Table 2.10. Disabled Medicare enrollees exhibited the highest rates of growth in discharges, days of care, and reimbursements, a reflection of rapid rate of increase in enrollment by disabled persons (Table 2.3).

Days of care for disabled Medicare enrollees grew 11.0 percent per year. Days of care for aged Medicare enrollees grew much more slowly, 2.4 percent per year. The rate of growth of Medicare reimbursements for short-stay hospital services increased faster for the aged (16.1 percent) and the disabled (26.9 percent) than that of Medicaid payments (14.0 percent).

Table 2.11 reports data on Medicare reimbursements and Medicaid payments for physicians' services. Like inpatient hospital services, physician reimbursements for disabled Medicare enrollees grew the fastest, 28.6 percent a year from 1974 to 1981. Medicaid payments for physicians' services grew the slowest, 9.4 percent a year from 1973 to 1982.

These trends are displayed in Figures 2.8 and 2.9. Medicaid payments have been growing more slowly than Medicare reimbursements in recent years. To some extent, this reflects the declining number of Medicaid recipients since 1977 (Figure 2.1).

Selected services

Medicare

Medicare reimbursement trends for skilled nursing care, outpatient services, and home health services are shown in Figure 2.10. The trend line for outpatient care graphically illustrates the sharp increase in reimbursements that occurred after the entry of disabled and ESRD enrollees in 1973. Tables 2.12, 2.13, and 2.14 present more detailed information on these trends.

Table 2.7

Medicare reimbursements, by type of coverage and type of enrollee: Calendar years 1966-81

Year	Hospital insurance and supplementary medical insurance				Hospital insurance				Supplementary medical insurance			
	Total	Aged[1]	Disabled[2]	ESRD[3]	Total	Aged[1]	Disabled[2]	ESRD[3]	Total	Aged[1]	Disabled[2]	ESRD[3]
	Amount in millions											
1966-67[4]	$5,145.2	$5,145.2	NA	NA	$3,839.9	$3,839.9	NA	NA	$1,305.3	$1,305.3	NA	NA
1968	5,289.5	5,289.5	NA	NA	3,766.9	3,766.9	NA	NA	1,522.6	1,522.6	NA	NA
1969	6,267.6	6,267.6	NA	NA	4,597.4	4,597.4	NA	NA	1,670.3	1,670.3	NA	NA
1970	6,572.0	6,572.0	NA	NA	4,740.3	4,740.3	NA	NA	1,831.6	1,831.6	NA	NA
1971	7,354.4	7,354.4	NA	NA	5,358.2	5,358.2	NA	NA	1,996.2	1,996.2	NA	NA
1972	8,019.4	8,019.4	NA	NA	5,835.7	5,835.7	NA	NA	2,183.7	2,183.7	NA	NA
1973	—	9,038.7	—	—	—	6,674.3	—	—	—	2,364.3	—	—
1974	11,238.0	10,257.5	$980.5	$184.4	8,118.4	7,454.4	$664.0	$44.6	3,119.6	2,803.1	$316.5	$139.8
1975	14,548.5	13,056.1	1,492.4	346.8	10,519.1	9,537.4	981.8	93.7	4,029.4	3,518.7	510.6	253.1
1976	17,619.0	15,636.5	1,982.5	492.0	12,793.9	11,495.8	1,298.1	134.3	4,825.1	4,140.7	684.4	357.7
1977	20,476.8	18,014.7	2,462.1	614.0	14,709.9	13,116.3	1,593.6	167.4	5,766.9	4,898.4	868.5	446.6
1978	23,542.7	20,579.1	2,963.6	744.0	16,630.3	14,740.7	1,889.7	196.6	6,912.4	5,838.4	1,073.9	548.1
1979	27,699.1	24,005.0	3,694.1	950.4	19,257.9	16,940.4	2,317.4	252.4	8,441.2	7,064.5	1,376.7	698.0
1980	33,724.7	29,224.2	4,500.5	1,207.0	23,194.2	20,404.1	2,790.1	330.2	10,530.5	8,820.1	1,710.4	876.8
1981	39,918.4	36,614.0	5,304.4	1,384.3	27,486.4	24,180.5	3,305.9	413.5	12,432.0	10,433.5	1,998.5	970.8
	Percent											
ACRG[5]	[6]16.8	[6]15.6	27.3	33.4	[6]15.4	[6]15.4	25.8	37.5	[6]17.5	[6]16.0	30.1	31.9

[1] For all enrollees 65 years of age or over, including those with end-stage renal disease.
[2] For all enrollees under 65 years of age, including those with end-stage renal disease.
[3] End-stage renal disease. Includes all aged and disabled enrollees with ESRD.
[4] July 1966 through December 1967.
[5] Average compound rate of growth.
[6] ACRG computed for 1968-81.

NOTE: These preliminary data are not adjusted for claims paid after data were compiled. Data do not correspond with data in Table 2.6, which include both interim reimbursements and retroactive adjustments made to institutional providers.

SOURCES: Health Care Financing Administration: *Medicare, Reimbursements by State and County,* annual issues for 1966-80. Washington. U. S. Government Printing Office; Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 2.8

Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal years 1973-82

Year	Cash assistance							Medical assistance only						
		SSI[1]			AFDC[2]				SSI[1]			AFDC[2]		
	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX[4]	Total[3]	Aged	Blind	Disabled	Children under 21 years	Adults	Other Title XIX
	Amount in millions													
1973	$4,736.5	$985.0	$46.4	$1,335.6	$1,048.5	$1,277.8	$44.3	$3,903.3	$2,250.5	$18.5	$680.5	$377.6	$168.3	$407.9
1974	5,640.8	1,177.5	54.5	1,605.2	1,319.6	1,447.3	36.6	4,342.1	2,513.7	25.3	783.1	374.6	257.1	388.2
1975	6,624.7	1,371.9	56.5	1,831.6	1,634.4	1,730.3	NA	5,667.7	3,277.3	27.0	1,042.1	415.8	282.7	622.8
1976	7,657.6	1,456.9	55.2	2,282.4	1,903.2	1,960.0	NA	6,477.0	3,734.8	31.0	1,267.1	449.7	284.9	709.5
1977[5]	9,214.8	1,894.2	67.6	2,964.5	2,083.4	2,205.1	NA	7,062.2	3,935.5	31.5	1,492.3	368.2	324.9	909.8
1978[5]	10,004.9	2,020.2	68.7	3,279.1	2,310.9	2,326.0	NA	7,960.7	4,401.1	33.5	1,845.5	365.9	340.7	974.0
1979	10,726.0	2,076.6	75.6	3,671.2	2,434.4	2,468.3	NA	9,747.5	5,570.3	47.6	2,432.6	430.0	367.5	899.5
1980	12,245.9	2,217.1	90.4	4,272.9	2,682.0	2,953.6	NA	11,055.1	6,469.6	51.8	2,742.1	458.3	418.8	913.9
1981	14,534.2	2,480.2	108.5	5,615.7	3,002.2	3,327.6	NA	12,670.1	7,445.9	45.5	3,685.1	506.1	435.0	552.5
1982	15,861.6	2,705.3	120.5	6,468.0	2,978.5	3,589.3	NA	13,537.8	8,033.8	51.9	3,764.7	495.0	503.8	688.5
	Percent													
ACRG[6]	14.4	11.9	11.2	19.2	12.3	12.2	NA	14.8	15.2	12.1	20.9	3.1	13.0	6.0

[1] Supplemental Security Income.
[2] Aid to Families With Dependent Children.
[3] Totals for each year include estimated payments for nonreporting States. Payments by basis of eligibility may not sum to total because of rounding.
[4] Cash assistance to other Title XIX recipients was phased out after 1974.
[5] Data for 1977 and 1978 have been adjusted to distribute small amounts of payments on behalf of persons whose basis of eligibility was unknown.
[6] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Figure 2.5

Percent distribution of enrollees and amounts reimbursed per enrollee under Medicare: Calendar year 1981

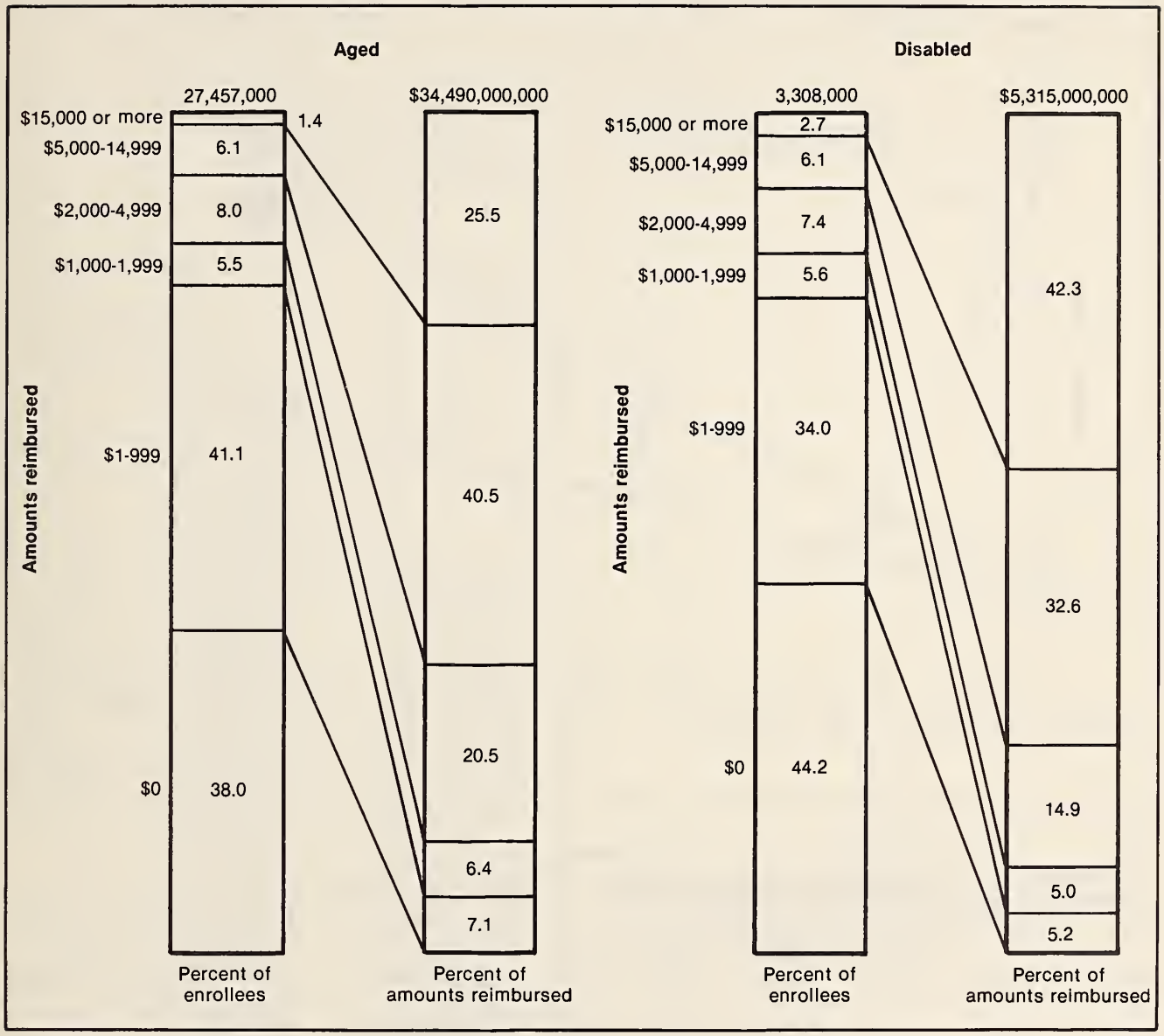


Figure 2.6

Medicaid payments for long-term care, inpatient hospital, and all other services: Fiscal years 1973-82

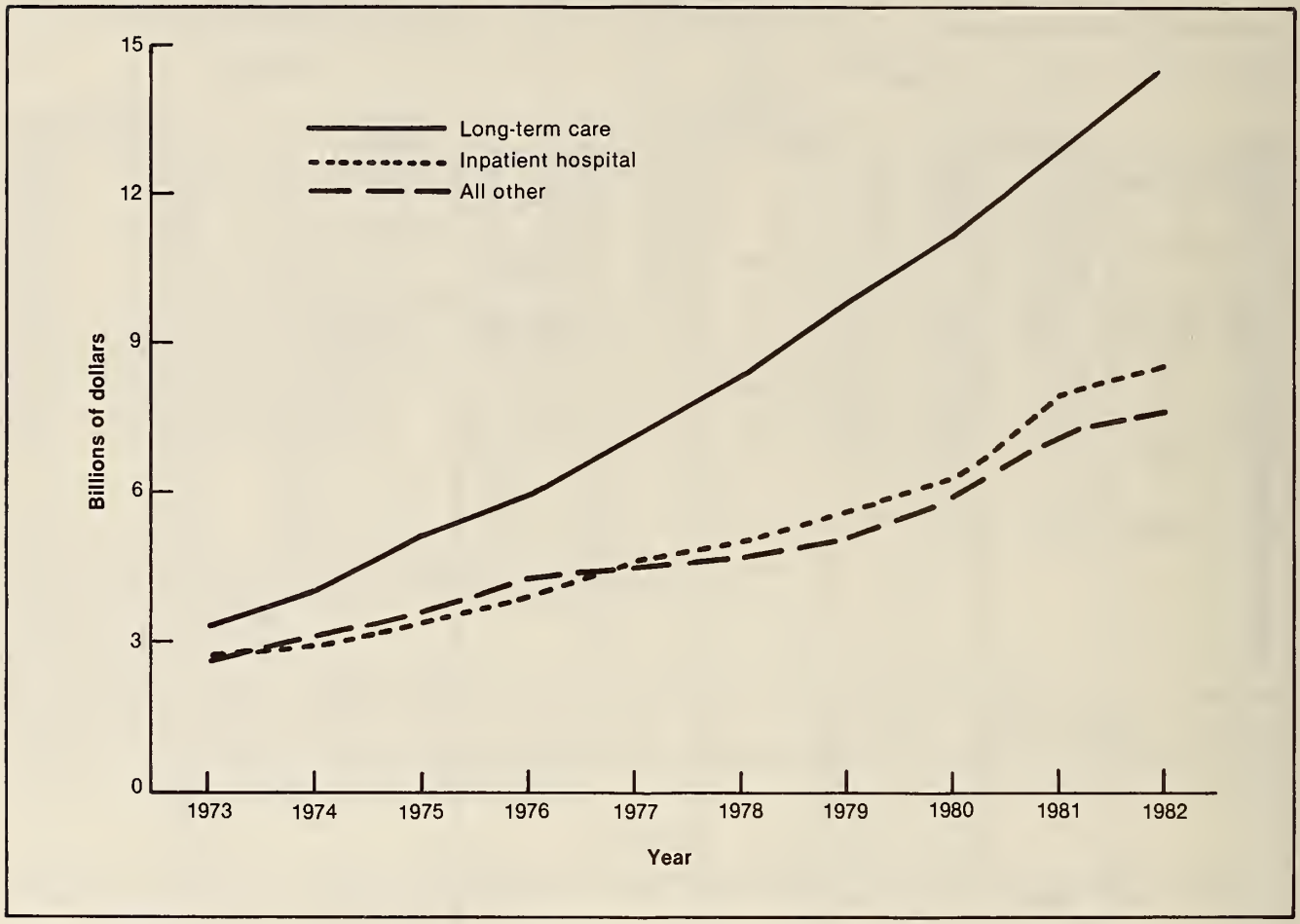


Table 2.9

Medicaid payments, by age, sex, and race: Fiscal years 1973-82

Year	Total	Age				Sex		Race		
		Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	All other	Unknown
					Amount in millions					
1973	$8,640	$537.4	$1,067.9	$3,696.2	$3,338.5	$2,886.6	$5,753.4	—	—	—
1974	9,983	601.0	1,335.7	4,140.0	3,906.3	3,235.5	6,747.5	—	—	—
1975	12,292	720.3	1,719.7	5,042.2	4,809.9	3,924.8	8,367.2	$5,944.2	$2,646.3	$3,701.5
1976	14,135	883.4	2,052.4	5,856.1	5,343.0	4,550.1	9,584.9	6,666.3	3,131.7	4,337.0
1977	16,277	1,002.7	2,465.0	6,881.9	5,926.5	5,286.8	10,990.2	8,153.4	3,554.4	4,569.3
1978	17,966	1,148.0	2,522.4	7,533.1	6,762.4	5,910.8	12,055.2	9,039.9	4,032.4	4,893.7
1979	20,474	1,244.8	2,712.8	8,523.3	7,995.1	6,678.6	13,795.4	11,053.1	5,272.0	4,148.9
1980	23,301	1,735.3	3,283.6	9,868.4	8,413.7	7,798.9	15,502.2	12,354.8	4,894.3	6,051.9
1981	27,204	2,040.3	3,319.0	11,099.4	10,745.7	9,113.4	18,090.9	18,635.0	6,257.0	2,312.3
1982	29,399	2,205.0	3,586.7	11,994.9	11,612.8	9,848.8	19,550.7	20,138.6	6,761.9	2,498.9
					Percent					
ACRG[1]	14.6	17.0	14.4	14.0	14.9	14.6	14.6	19.0	14.3	−5.5

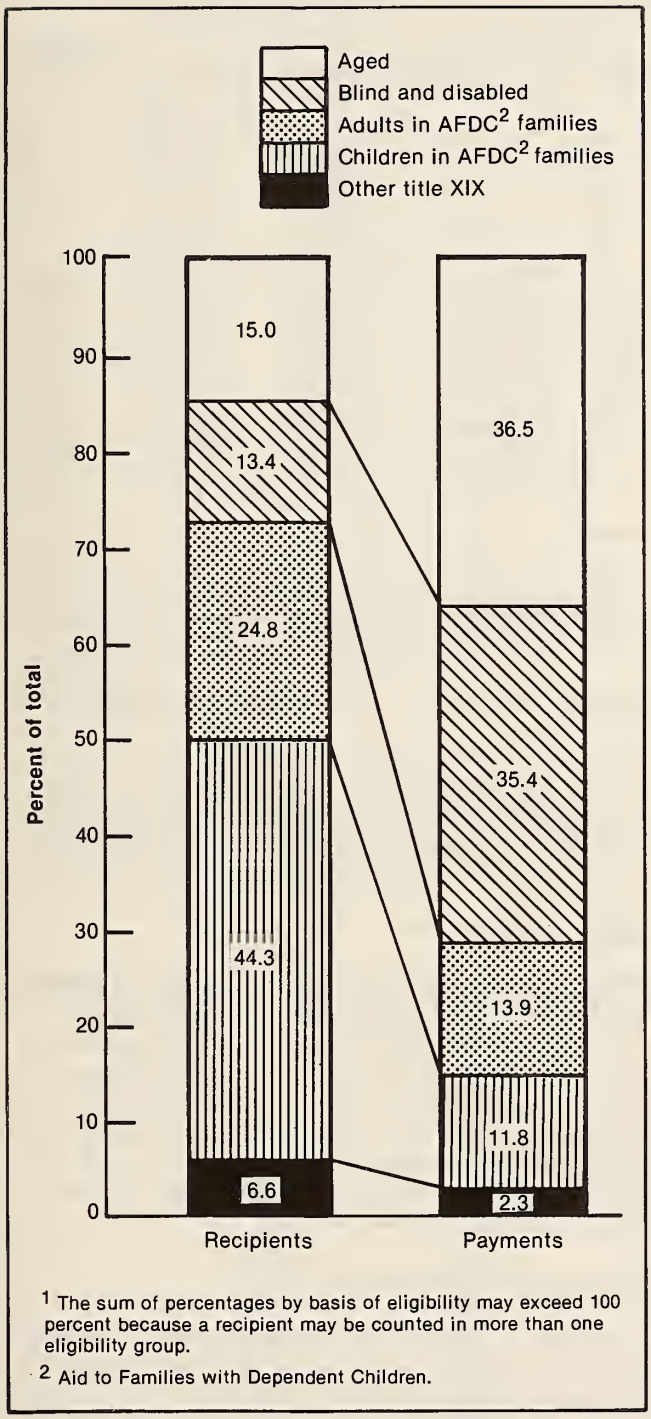
[1] Annual compound rate of growth.

NOTE: A small number of persons of unknown age or sex have been distributed among age and sex categories. However, the number of persons of unknown race is too great to be accurately estimated. Consequently, data by race should be used with caution.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Figure 2.7

Percent distribution of Medicaid recipients and payments, by basis of eligibility: Fiscal year 1982



[1] The sum of percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.

[2] Aid to Families with Dependent Children.

Figure 2.8

Medicare reimbursements and Medicaid payments for short-stay hospital services: 1967-82

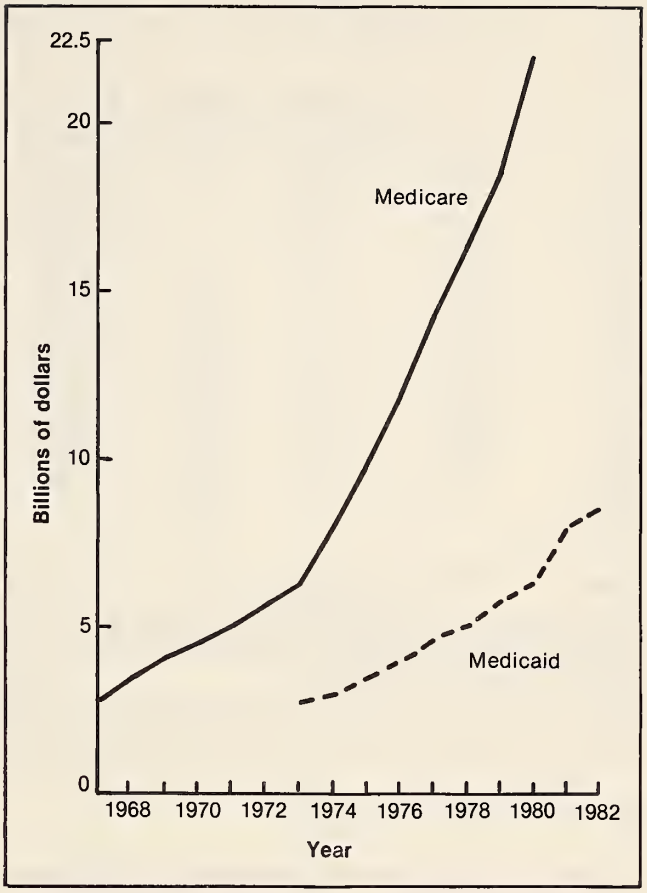


Figure 2.9

Medicare reimbursements for physicians'and other medical services and Medicaid payments for physicians' services: 1966-82

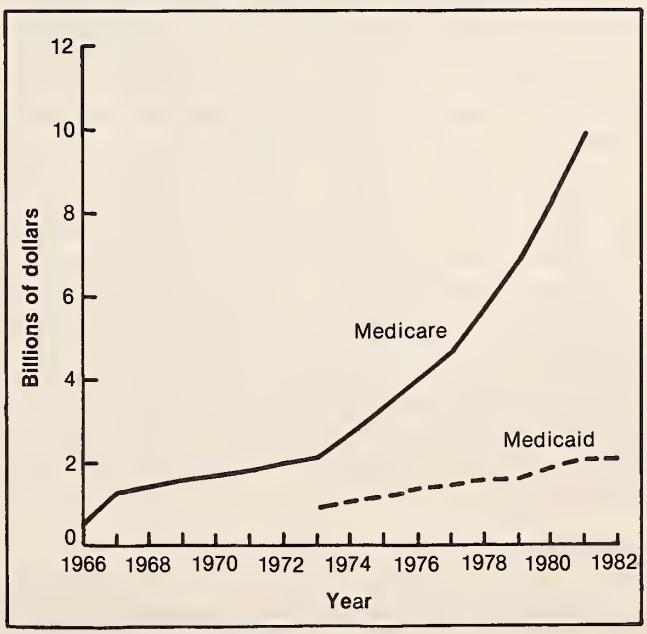


Table 2.10

Use of short-stay hospitals under Medicare and Medicaid: 1967-82

Year	Discharges			Days of care			Medicare reimbursements		
	Medicare			Medicare[1]					
	Aged	Disabled	Medicaid	Aged	Disabled	Medicaid	Aged	Disabled	Medicaid payments
	Number in thousands						Amount in millions		
1967	5,228	NA	—	68,487	NA	—	$ 2,760	NA	—
1968	5,641	NA	—	75,589	NA	—	3,509	NA	—
1969	5,852	NA	—	77,246	NA	—	4,085	NA	—
1970	5,951	NA	—	75,578	NA	—	4,481	NA	—
1971	6,090	NA	—	74,298	NA	—	5,036	NA	—
1972	6,380	NA	4,021	75,284	NA	28,147	5,576	NA	—
1973	6,751	—	4,624	77,637	—	32,368	6,245	—	$2,660
1974	7,033	604	4,673	79,770	6,378	32,711	7,209	$621	2,887
1975	7,285	724	4,879	80,135	7,370	34,153	8,859	876	3,411
1976	7,607	863	5,034	82,916	8,661	35,238	10,589	1,183	3,938
1977	7,963	984	5,366	86,662	9,991	37,562	12,627	1,545	4,603
1978	8,280	1,076	5,507	88,552	10,730	38,549	14,422	1,857	4,985
1979	8,541	1,165	5,271	89,532	11,426	36,897	16,312	2,201	5,650
1980[2]	9,068	1,228	5,308	93,845	11,960	37,156	19,281	2,597	6,283
1981	—	—	5,282	—	—	36,974	—	—	8,071
1982	—	—	5,096	—	—	35,672	—	—	8,644
					Percent				
ACRG[3]	4.3	12.6	4.5	2.4	11.0	1.6	16.1	26.9	14.0

[1] Days of care covered by Medicare; covered days constitute more than 95 percent of total days of care.
[2] Medicare data based on discharge stay records recorded as of December 1981. Data for 1980 are understated by about 3 percent compared with earlier years.
[3] Annual compound rate of growth.

NOTE: Medicare data are for calendar years; Medicaid data are for fiscal years.

SOURCES: Medicare data: Health Care Financing Administration, Office of Statistics and Data Management: unpublished data. Medicaid data: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Skilled nursing facility services

Data on the use of and reimbursements for skilled nursing facility (SNF) services are presented in Table 2.12. Data are based on bills incurred in a calendar year. Among aged enrollees, the number of covered days of SNF care decreased by 62 percent from 1969 (the first year data were collected) through 1972. From 1976 through 1981, the number of covered days fell steadily. The average annual rate of decrease for covered days among the aged during the period 1969-81 was 6.5 percent. The decline resulted from administrative limitations on Medicare SNF benefits. By law benefits are targeted for enrollees requiring skilled nursing services but not custodial care.

In 1981, Medicare disabled enrollees accounted for only 3.5 percent of total covered days in SNF's. From 1974 (the first full year of coverage) through 1981, the number of covered days of care used by the disabled increased at an annual average rate of .4 percent. Among the aged, the decline in covered days of care resulted in reimbursement declines during the period 1969-72; only in 1973 did reimbursements begin to rise. By 1981, SNF reimbursements for the aged were only 11 percent above the 1969 level. In contrast, reimbursements for the disabled rose at an average annual rate of 8.5 percent from 1974 through 1981.

Outpatient services

For both aged and disabled enrollees, reimbursements for outpatient care grew more rapidly than reimbursements for any other service (Table 2.13 and Figure 2.10). The disabled accounted for over one-third of outpatient reimbursements; this again reflects the impact of the ESRD population on the SMI program.

Home health services

Data on the use of and reimbursements for home health services during the period 1969-81 are presented in Table 2.14. The rapid increase in both visits and reimbursements since 1972 partly reflects the 1972 Social Security Amendments, which extended coverage to the disabled and those with end-stage renal disease and expanded payments and coverage of home health care. Overall, reimbursement grew at a rate about 2.3 times faster than that for number of visits.

Services to ESRD enrollees

Table 2.15 presents ESRD reimbursements, enrollments, and per capita reimbursements for 1974-81. For more information on ESRD patients under Medicare, see Eggers (1984). In 1974, the first full year of coverage of ESRD patients, total Medicare reimbursements for the ESRD program were $229 million. By 1981, reimbursements had risen to $1,466 million: over six times more than the amount in 1974, or an annual growth rate of 30.4 percent. However, the rate of growth has slowed considerably in recent years. From 1974 to 1975, the rate of growth was 58 percent. The growth had slowed to 17.4 percent by the most recent years, 1980-81.

Table 2.11

Medicare reimbursements for physicians' and other medical services and Medicaid payments for physicians' services: 1966-82

Year	Medicare reimbursements[1]		Medicaid payments
	Aged	Disabled	
	Amount in millions		
1966[2]	$431.0	NA	—
1967	1,223.8	NA	—
1968	1,437.0	NA	—
1969	1,609.0	NA	—
1970	—	NA	—
1971	1,847.7	NA	—
1972	2,028.8	NA	—
1973	2,112.0	—	$925.9
1974	2,534.0	$206.2	1,083.4
1975	3,050.0	295.2	1,247.7
1976	3,633.0	389.1	1,388.6
1977	4,177.0	481.5	1,525.5
1978	5,145.0	556.5	1,595.9
1979	6,045.0	809.7	1,637.5
1980	7,361.4	996.9	1,872.9
1981	8,688.5	1,198.9	2,101.4
1982	—	—	2,085.5
	Percent		
ACRG[3]	[4] 15.0	28.6	9.4

[1] Reimbursements for physicians' services, ambulance services, independent laboratory services, durable medical equipment, and prosthetic devices are included. Therefore, these data are not directly comparable with Medicaid payments, which cover only physicians' services.
[2] July-December only.
[3] Annual compound rate of growth.
[4] ACRG computed for 1967-81 only.

NOTE: Medicare data are for calendar years; Medicaid data are for fiscal years.

SOURCES: Medicare statistics: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981*. HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983. Medicaid statistics: Health Care Financing Administration, Office of the Actuary: Unpublished data.

Figure 2.10

Medicare reimbursements for selected services: Calendar years 1966-81

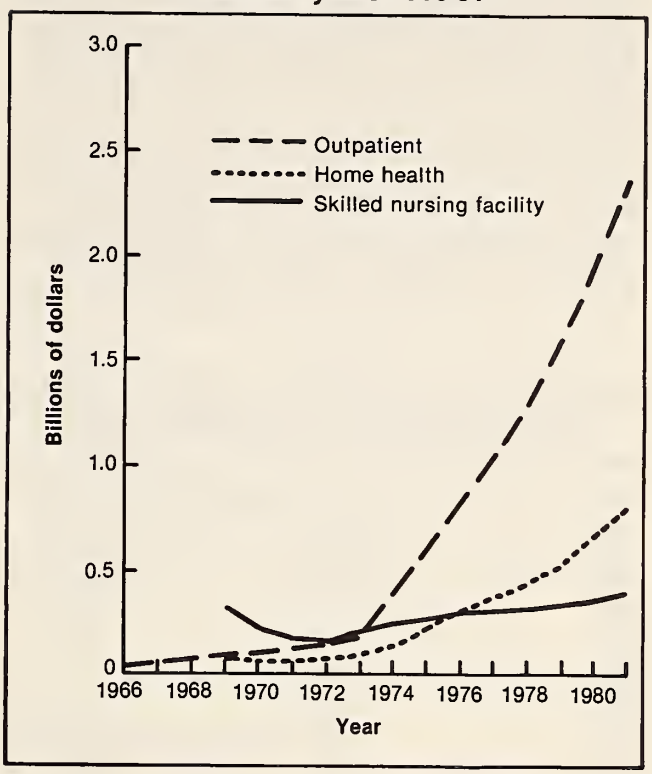


Table 2.12

Medicare covered days of care, covered charges, and reimbursements for skilled nursing facility services, by type of enrollee: Calendar years 1969-81

Year	Covered days of care		Covered charges		Reimbursements	
	Aged	Disabled	Aged	Disabled	Aged	Disabled
	Number in thousands		Amount in millions			
1969	17,572.5	NA	$432.2	NA	$335.0	NA
1970	10,697.1	NA	295.1	NA	225.6	NA
1971	7,481.1	NA	229.9	NA	178.7	NA
1972	6,628.0	NA	212.1	NA	164.1	NA
1973[1]	8,523.0	106.4	278.1	$4.0	209.8	$2.9
1974	8,687.9	277.0	322.9	11.8	237.6	8.3
1975	8,584.7	289.1	405.5	14.8	251.5	9.6
1976	9,406.7	316.6	448.7	17.6	293.5	11.2
1977	9,296.4	334.8	478.5	20.0	301.0	12.3
1978	8,643.0	315.0	493.9	20.7	304.0	12.5
1979	8,133.6	314.5	522.3	22.9	315.6	13.5
1980	8,125.9	306.0	579.8	24.6	343.0	13.9
1981[2]	7,875.6	284.2	639.1	26.5	371.0	14.7
			Percent			
ACRG[3]	-6.5	[4] 0.4	3.3	[4] 12.3	0.9	[2] 8.5

[1] July-December only.
[2] Preliminary estimates.
[3] Annual compound rate of growth.
[4] ACRG computed for 1974-81 only.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: unpublished data.

This pattern of growth in reimbursements is largely attributable to the growth in the ESRD population: 16,000 ESRD enrollees in 1974 and a total of 64,100 (four times greater) in 1981. Enrollment increases were greatest in the early years of the program. Although the overall annual growth rate was 21.9 percent, the 1974-75 change was 41.9 percent, compared with only 10.9 percent for 1980-81.

The growth rate in ESRD enrollees reflects the unique nature of this Medicare population. Before Medicare covered ESRD patients, most people with ESRD died because of lack of funding for the very expensive dialysis maintenance therapy or for transplant operations. Thus, in July 1973, when the ESRD program began, it mainly served people whose onset of ESRD occurred in 1973. In 1974, the program served people whose ESRD onset occurred in 1974 plus survivors whose treatment began in 1973. In 1975, new ESRD patients were added to cohorts from the two previous years, and so on. As enrollment grew, the number of deaths among the carryover population (annual mortality even with dialysis is about 20 percent) began to approach the number of new entries. Thus, the overall growth rate has slowed considerably.

Reimbursements per enrollee rose from $14,300 in 1974 to $22,900 in 1981. The annual growth rate of only 7.0 percent results mainly from a cap of $138 in the allowed charge per dialysis (with some exceptions) since the program began. Dialysis reimbursements amount to about 60 percent of reimbursements for ESRD patients. The remainder are mostly for inpatient hospital care and physician services, which have not been subject to a reimbursement cap.

Table 2.13

Medicare reimbursements for outpatient services, by type of enrollee: Calendar years 1966-81

Year	Aged	Disabled
	Amount in millions	
1966[1]	$38.3	NA
1967	56.7	NA
1968	78.6	NA
1969	103.1	NA
1970	—	NA
1971	124.5	NA
1972	148.2	NA
1973	179.2	—
1974	252.5	$145.3
1975	374.4	221.2
1976	516.2	308.8
1977	649.0	391.7
1978	798.0	480.4
1979	997.1	582.9
1980	1,260.7	700.7
1981	1,556.6	791.3
	Percent	
ACRG[2]	[3] 26.7	27.4

[1] July-December only.
[2] Annual compound rate of growth.
[3] ACRG computer for 1967-81 only.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 2.14

Medicare visits and reimbursements for home health services: Calendar years 1969-81

Year	Visits in thousands	Reimbursements in millions
1969	8,500	$78.1
1970	6,000	61.5
1971	4,800	56.8
1972	5,200	65.9
1973	6,400	92.9
1974	8,200	144.3
1975	10,900	217.0
1976	13,500	294.6
1977	15,600	366.5
1978	17,100	426.9
1979	19,200	518.2
1980	22,400	662.1
1981	24,420	801.3
	Percent	
ACRG[1]	9.2	21.4

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Unpublished data.

Table 2.15

Medicare reimbursements, enrollees, and reimbursements per enrollee for persons with end-stage renal disease: Calendar years 1974-81

	Reimbursements		Enrollees[1]		Reimbursement per enrollee	
Year	Amount in millions	Percent change	Number in thousands	Percent change	Amount	Percent change
1974	$228.5	NA	16.0	NA	$14,300	NA
1975	361.1	58.0	22.7	41.9	15,900	11.2
1976	512.2	41.8	28.9	27.3	17,700	11.3
1977	641.3	25.2	34.8	20.4	18,400	4.0
1978	799.1	24.6	43.1	23.9	18,500	.5
1979	1,009.3	26.3	50.8	17.9	19,900	7.6
1980	1,248.6	23.7	57.8	13.8	21,600	8.5
1981	1,466.1	17.4	64.1	10.9	22,900	6.0
			Percent			
ACRG[2]	30.4	NA	21.9	NA	7.0	NA

[1] Includes aged and disabled Medicare enrollees entitled under Public Law 92-603, Section 299I, "end-stage renal disease only."
[2] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: ESRD Archival Reimbursement Abstract, unpublished data.

Parceling out the growth in total ESRD reimbursements into the two components of enrollment and per capita reimbursements shows that 76 percent of the growth is attributable to enrollment increases and only 24 percent to increases in reimbursements per enrollee. (See Klarman et al., 1970, for the parceling method.)

Medicaid

Trends in Medicaid payments for skilled nursing and intermediate care facilities are shown in Figure 2.11. Data on Medicaid payments for hospital outpatient services, home health services, and drug prescriptions are shown in Figure 2.12. Detailed information on changes in these services is presented in Tables 2.16-2.20.

Skilled nursing facilities and intermediate care facilities—Table 2.16 reports data on use of and payments to skilled nursing facilities under Medicaid. During the period 1973-82, recipients in skilled nursing facilities and total days of care declined at annual rates of 2.1 and 1.1 percent, respectively. Both declined from 1973 to 1975 but have fluctuated since then. In spite of these fluctuations in use, payments grew steadily at an annual rate of 9.5 percent.

Data on trends in use of and payments to intermediate care facilities during the period 1975-82 are presented in Table 2.17. Payments grew at an annual rate of 15.0 percent. The number of recipients and days of care grew more slowly, 2.4 and 3.4 percent per year, respectively.

Hospital outpatient services—Data on Medicaid utilization of hospital outpatient services during the period 1973-82 are reported in Table 2.18. The number of recipients grew 7.1 percent annually from 1973 through 1982, and payments increased almost three times faster than recipients.

Home health services—As shown in Table 2.19, home health care is one of the fastest growing services covered by Medicaid. From 1973 through 1982, the number of recipients increased at an average annual rate of 14.7 percent. Payments grew at an even higher rate, 39.1 percent per year.

Prescription drugs—Data on use of and payments for prescription drugs under Medicaid are shown in Table 2.20. Both the number of recipients and number of prescriptions grew over the period, with the growth in the number of prescriptions outpacing that of recipients. The number of prescriptions per recipient grew at a rate of 2.4 percent per year, increasing from 10.5 in 1973 to 13.0 per recipient in 1982. Payments for prescriptions grew steadily at an annual rate of 11.3 percent.

Figure 2.11

Medicaid payments for nursing facility services, by type of service: Fiscal years 1973-82

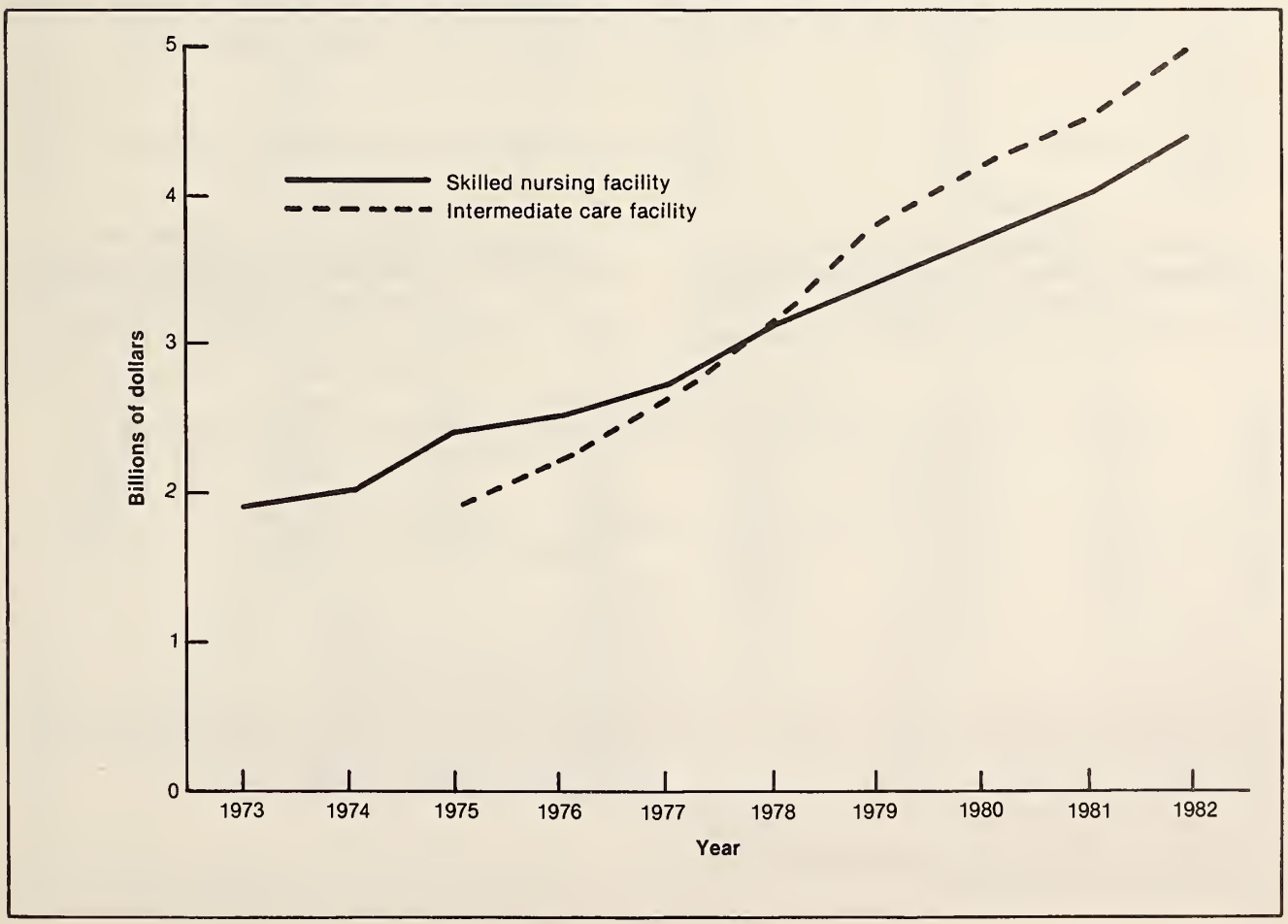


Figure 2.12

Medicaid payments for selected services: Fiscal years 1973-82

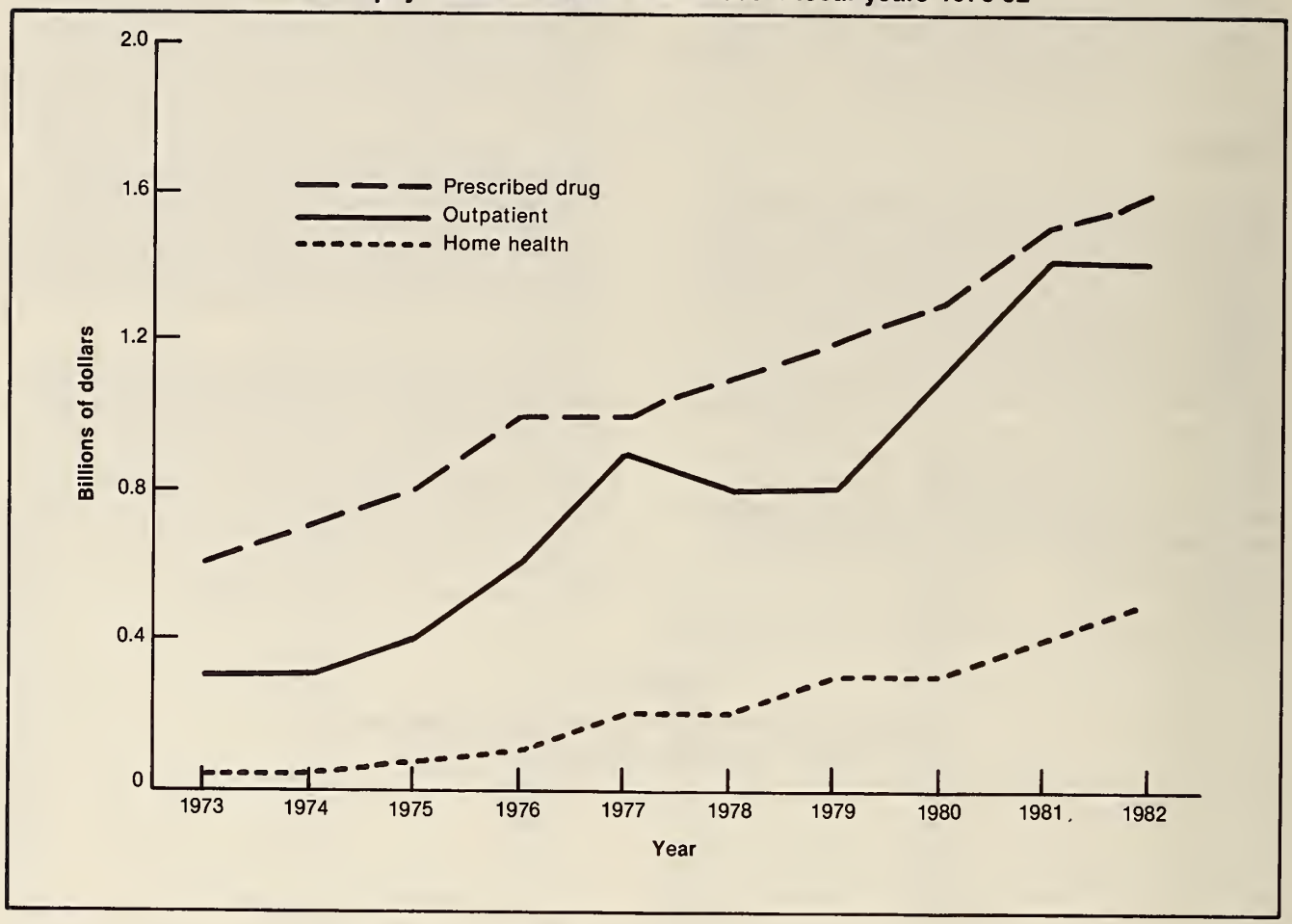


Table 2.16

Medicaid recipients, days of care, and payments for skilled nursing facility services: Fiscal years 1973-82

Year	Recipients	Days of care	Payments
	Number in thousands		Amount in millions
1973[1]	678	133,905.0	$1,958.9
1974[2]	661	130,547.5	2,001.9
1975	611	120,672.5	2,466.2
1976	619	122,252.5	2,488.4
1977	631	124,622.5	2,686.9
1978	635	125,412.5	3,093.6
1979	593	117,117.5	3,368.8
1980	609	120,277.5	3,706.5
1981	623	125,412.5	4,035.4
1982	559	110,205.0	4,426.7
		Percent	
ACRG[3]	−2.1	−1.1	9.5

[1] Includes intermediate care facilities in Michigan.
[2] Includes intermediate care facilities in West Virginia, Missouri, and North Carolina.
[3] Annual compound rate of growth.

NOTE: Estimates were made for States with missing data. Therefore, figures may differ from those in Table 4.12.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Table 2.17

Medicaid recipients, days of care, and payments for intermediate care facility services: Fiscal years 1975-82

Year	Recipients	Days of care	Payments
	Number in thousands		Amount in millions
1975	647	167,184.8	$1,866.7
1976	692	178,812.8	2,189.1
1977	748	193,283.2	2,647.4
1978	739	190,957.6	3,120.8
1979	752	194,316.8	3,770.9
1980	789	203,877.6	4,221.3
1981	762	199,484.8	4,506.7
1982	765	197,934.4	4,979.0
		Percent	
ACRG[1]	2.4	3.4	15.0

[1] Annual compound rate of growth.

NOTE: Data exclude intermediate care facilities for the mentally retarded. Data for 1973 and 1974 are not available. Estimates were made for States with missing data. Therefore, figures may differ from those in Table 4.12.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Evolution of Medicare and Medicaid programs

In this concluding section of Chapter 2, Medicare and Medicaid program trends are explored. The Medicare program is analyzed by describing policy changes in hospital care because hospital care costs are its major expenditure (Dobson and Bialek, 1983). Next, the evolution of the Medicaid program is described in terms of changes in the factors that have determined the growth of Medicaid expenditures from the beginning of the program to the present (Muse and Beisel).

Medicare hospital care policy

Overview

Since Medicare coverage for persons 65 years of age or over was enacted in 1965, the program has been evolving and undergoing substantial changes (Dobson and Bialek, 1983). At first, the major emphasis was on expanding access to health care for the elderly and other subsets of the population (the disabled and persons with end-stage renal disease). Today, the overriding concern is to develop methods for limiting expenditure increases. The following dicussion concentrates on the evolution of the inpatient hospital portion of the Medicare HI program, which consumes most (66 percent) of the program's expenditures (Figure 1.1).

Three policy phases

The evolution of the Medicare program is examined in three phases. Throughout the first phase, 1965-72, the main national concern was to improve access to health care. However, expenditures rose faster than anticipated, prompting the initiation of programs for limiting expenditures increases. During the second phase, 1973-79, attempts to limit medical care spending by regulatory devices dominated health care policy. Additional regulatory programs were implemented and found to be ineffective in controlling hospital costs during this period. The inability to control costs through regulatory efforts prompted

Table 2.18

Medicaid recipients and payments for hospital outpatient services: Fiscal years 1973-82

Year	Recipients in thousands	Payments in millions
1973	5,295.4	$267.6
1974	5,544.5	322.0
1975	6,157.8	377.2
1976	6,980.7	556.3
1977	8,332.7	885.2
1978	8,287.9	831.6
1979	7,505.7	836.7
1980	9,577.5	1,102.1
1981	10,017.9	1,409.1
1982	9,852.5	1,437.7
	Percent	
ACRG[1]	7.1	20.5

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Table 2.19

Medicaid recipients and payments for home health services: Fiscal years 1973-82

Year	Recipients in thousands	Payments in millions
1973	109.9	$25.4
1974	134.7	31.1
1975	202.4	70.3
1976	227.2	134.3
1977	363.1	180.0
1978	358.2	209.8
1979	358.4	263.6
1980	393.6	331.8
1981	401.7	427.8
1982	377.3	495.5
	Percent	
ACRG[1]	14.7	39.1

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Table 2.20

Selected measures of use of prescription drugs under Medicaid: Fiscal years 1973-82

Year	Recipients	Prescriptions	Number of prescriptions per recipient	Payments in millions
	Number in thousands			
1973	12,116.2	127,293.4	10.5	$609.3
1974	14,240.0	143,179.5	10.2	712.6
1975	13,888.0	154,701.1	11.0	832.2
1976	14,770.0	170,287.8	11.9	957.0
1977	15,420.0	173,891.1	11.6	1,027.2
1978	15,251.0	176,991.2	12.0	1,084.1
1979	14,189.0	177,657.2	12.5	1,202.4
1980	13,765.7	169,457.2	12.3	1,321.2
1981	14,255.7	176,215.0	12.4	1,534.7
1982	13,546.7	175,830.8	13.0	1,598.9
		Percent		
ACRG[1]	1.2	3.6	2.4	11.3

[1] Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

calls for other approaches to Medicare policy development in Phase 3, which began in 1980 and is still evolving. Competitive solutions have gained favor over regulatory options and the Medicare prospective payment system (PPS) has been enacted. A new sense of urgency for controlling expenditures emerged during this phase; demographic data and cost projections indicate that, without cost containment, higher taxes, and/or reduced benefits, the Medicare HI trust fund faces bankruptcy by the middle of the next decade.

Phase 1, 1965-72: Emergence of Medicare and conflicts in policy objectives—With the Social Security Act Amendments of 1965 (Public Law 89-97), comprehensive health care legislation for the aged was enacted under Medicare. The program, providing hospital insurance and supplementary medical insurance, improved the elderly's ability to obtain adequate hospital and ambulatory care. The Medicare reimbursement method, retrospective cost reimbursement, was based on private industry practices. Almost as soon as the Medicare program was implemented, access to health care for the elderly increased sharply and, as a result, program expenditures rose rapidly.

In 1967, Social Security Act Amendments (Public Law 90-248) authorized the Department of Health, Education, and Welfare (presently the Department of Health and Human Services and referred to here as DHHS) to study the impact of extending benefits under the Medicare program to disadvantaged groups, such as the disabled and persons with ESRD. In addition, Congress mandated studies and experiments for developing reimbursement systems that would help control growing health care expenditures. Data indicated that the retrospective cost-based model for reimbursement was leading to a rapid increase in hospital care expenditures. Experiments to test and develop alternatives to this reimbursement model were authorized.

During the period 1967-71, Federal Medicare hospital expenditures continued to rise. They increased from $2.66 billion to $5.16 billion, an average rate of increase of 18 percent compared with the Consumer Price Index annual rate of increase of only 5 percent. Federal Government and private researchers now began to examine hospital services in order to develop payment mechanisms that would be equitable across hospital settings, yet effective in controlling the growth of expenditures. The Federal Government took a dramatic step toward controlling cost with the enactment in 1971 of the Economic Stabilization Program (ESP). But this program was only temporary and was lifted in 1974.

Another subject of national interest in the decade following the implementation of Medicare, was the concept of national health insurance. Because costs were rising and controls were being sought, only incremental changes were possible. Federal Government studies indicated special access problems for persons with ESRD and the disabled. In 1972, the Social Security Act was amended (Public Law 92-603) to give Medicare coverage to persons with ESRD and disabled workers receiving cash benefits under the Social Security Act.

Both expanding access to health care and reducing costs were addressed in the 1972 Amendments. In addition to extending Medicare to the disabled and persons with ESRD, the Amendments dealt with the problems of the elderly not previously eligible for Medicare coverage, permitting them to pay the full premium for HI and obtain health insurance at a more affordable rate. On the cost control side, professional standards review organizations (PSRO's) were mandated because hospital utilization review had appeared to be somewhat successful in reducing unnecessary utilization of services in a few States. Benefits were extended to Medicare enrollees using health maintenance organizations (HMO's), anticipating that HMO's would reduce per capita inpatient hospital admissions, as demonstrated by federally and privately sponsored group practice prepayment plans. Finally, DHHS was given more precise authority to withhold payments to hospitals for unreasonable expenses. Under Section 223, DHHS was mandated to group hospitals by size, location, and other factors and to determine prospective per diem reasonable charge limits. In addition, the Amendments mandated the continuation and expansion of research and experimentation for improving health care access and controlling costs.

Phase 2, 1973-79: Shifting emphasis of Medicare policy—During the first year of this phase, ESP kept hospital expenditures increases down. However, Congress realized that ESP was only a temporary measure and continued its search for additional cost controls. Indeed, when ESP was lifted in 1974, hospital inpatient costs began rising rapidly once again.

The National Health Planning and Resources Act of 1974 (Public Law 93-641) was enacted in response to the need for additional regulatory programs. This legislation authorized the establishment of community health planning agencies, required certificates of need (CON's) for reimbursement for hospital capital expenditures and permitted DHHS to set limits on hospital charges and routine costs.

As this phase progressed, research and experimentation intensified. State ratesetting programs were proving effective, in varying degrees, but the Federal mechanisms such as PSRO's and CON's, appeared to have little positive impact. The Health Care Financing Administration (HCFA) was established during this phase, in 1977, to administer Federal health care financing programs and assure their quality.

Toward the end of this period, hospitals voluntarily established committees for controlling expenditures. These voluntary controls, enacted in 1978, reduced hospital expenditure increases at a time when the second OPEC boycott caused rapid inflation throughout the economy. The seeming success of voluntary controls and the failure of Federal regulations prompted a new spirit of voluntary intervention for controlling expenditures.

Phase 3, 1980-present: Dominance of fiscal constraints and emergence of prospective reimbursement—Voluntary controls proved to be only temporarily effective. In 1980, Medicare hospital expenditures were rising even faster than before relative to the Consumer Price Index. A strong need to control expenditures was felt, as analysis of the "aging" of the population indicated that continued unrestrained growth of expenditures would lead to insolvency of the HI trust fund by the middle of the next decade.

Overwhelming emphasis is now being placed on developing policies for solving this problem.

Following the failure of voluntary controls, Congress enacted far-reaching fiscal constraints. In 1982, it passed the Tax Equity and Fiscal Responsibility Act (TEFRA, Public Law 97-248). Under TEFRA, limits on hospital reimbursement based on case mix were established, controlling ancillary costs as well as operating costs. Peer review organizations (PRO's) replaced PSRO's. The development of a national Medicare prospective payment system for future implementation was mandated. TEFRA placed payment limits on per-case rather than per diem costs for the first time and introduced a Medicare case-mix index.

In April 1983, Congress passed the Social Security Act Amendments of 1983 (Public Law 98-21). The Amendments provide for the phased-in implementation of PPS, using a diagnosis-related group (DRG) ratesetting system for Medicare hospital reimbursement. The new program replaced the TEFRA budgetary mechanism, but imposed identical budgetary constraints through the "budget neutral" provision whereby, in the aggregate, PPS will not reimburse hospitals for amounts above those expected under TEFRA. Unlike TEFRA, PPS establishes a uniform price for a case, not merely a cap on the reimbursement level. The purpose of PPS is to provide incentives for more efficient production of hospital services by setting a price for a product as opposed to reimbursing on a retrospective cost basis. To supplement PPS, a large number of studies were mandated for adjusting DRG rates, evaluating prospective payment program impacts, developing refinements to the DRG system, and expanding PPS to facilities other than hospitals and to physicians in the inpatient setting.

A successful PPS may be a vital factor in maintaining the solvency of the HI trust fund. However, Congress may need to further refine or strengthen PPS and to implement other measures for preserving the trust fund. Changes in physician payment systems are receiving increasing attention.

Medicaid expenditure trends

Overview

Factors that contribute to the growth in Medicaid expenditures from the start of the program in 1965 through 1982 are discussed in this section. Medicaid program expenditures have risen very rapidly, from $1.6 billion in CY 1965 to $29.4 billion in FY 1982.

In this discussion, a model in the form of a simple equation is used to quantify the factors contributing to the growth in program expenditures. Total expenditures are postulated to be a function of the medical services offered (utilization), the program's eligibility policies (population), reimbursement policies (price), and administration costs. These factors are a function of utilization, population, price, and administration, and are expressed in the following equation.[6]

Total expenditures = F (Utilization, Population, Price) + Administration.

Price, like other factors in the equation, has several components. It includes the costs of medical services and the intensity of services (number of services per recipient).

Four eras

In this discussion, the growth of Medicaid expenditures is examined in terms of significant changes in the factors of the equation over four time periods.

Era 1 CY 1965-71: Startup—The first era represents the startup of the Medicaid program. Some States implemented Medicaid immediately, but others took several years. By CY 1971, the Medicaid program had reached $6.3 billion in combined Federal and State expenditures, or an average annual rate of increase from CY 1965 to CY 1971 of 31 percent. The $6.3 billion in CY 1971 was approximately double the original budget estimate of what Medicaid would be in 1971. Table 2.21 shows that the three factors accounting for the 31-percent increase in expenditures were: population, 14 percent; utilization, 11 percent; and price, only 6 percent.

The original Medicaid budget estimates severely understated the scope of the services that would be voluntarily offered by States. Specifically, it was assumed that only a handful of States would offer coverage to the medically needy population. Further, the number of persons eligible for the program was underestimated by about 95 percent. The growth in the medically needy population was the major contributor to the rapid rise of Medicaid expenditures in this era.

Era 2, FY 1972-75: The 1972 Amendments—The 1972 Amendments to the Social Security Act marked the next era in Medicaid expenditure growth. First, this legislation significantly expanded the services offered by Medicaid, particularly intermediate care facilities for the mentally retarded (ICF-MR's). Second, Congress broadened the definition of disability, thus increasing the population eligible for Medicaid. The per capita expenses of disabled and ICF-MR recipients are among the highest incurred by Medicaid recipients. Most of the rapid growth of ICF-MR services and the disabled Medicaid population, spurred by the 1972 Amendments, took place in era 2.

In the second era, the average annual growth rate was 23 percent. Price, with an average annual increase of 10 percent, was now the largest component of the increase in expenditures. Population at 7 percent and utilization at 6 percent also contributed to the 23-percent increase.

In the first two eras, two important changes occurred in health care coverage of the poor. Medicaid was largely responsible for these changes. First, prior to 1965, national health surveys showed that the poor received significantly fewer services than the nonpoor. Starting in 1976, these differences began to lessen. Second, prior to 1965, local governments and charitable organizations provided most of the money for health care for the poor. However, in eras 1 and 2, Federal and State Governments became the dominant source of health care funds for the poor.

[6] For an overview of this method, see Harriott and Muse (1973).

Table 2.21

Contribution of utilization, population, and price to the growth of Medicaid expenditures: 1965-82

Era	Average annual rate of change			
	Total expenditures	Utilization	Population	Price
		Percent		
Era 1: CY 1965-CY 1971	31	11	14	6
Era 2: FY 1972-FY 1975	23	6	7	10
Era 3: FY 1976-FY 1980	13	2	−1	12
Era 4: FY 1981-FY 1982	12	1	0	11
		Percent distribution		
Era 1: CY 1965-CY 1971	100.0	35.4	45.2	19.4
Era 2: FY 1972-FY 1975	100.0	26.1	30.4	43.5
Era 3: FY 1976-FY 1980	100.0	15.4	−7.7	92.3
Era 4: FY 1981-FY 1982	100.0	8.3	0	91.7

SOURCE: Muse, D. N., and Beisel, R. H.: Medicaid Trends: Past, Present and Future. Unpublished paper.

Era 3, FY 1976-80: Medicaid Inflation—Medicaid expenditures increased from $14.1 billion in FY 1976 to $23.3 billion in FY 1980. However, the number of recipients decreased from 22.9 million to 21.6 million in the same period. Further, no significant national expansion of Medicaid services or eligibility coverage occurred during this era.

Medicaid expenditures grew at an annual average rate of 13 percent, slower than in the two previous eras. The 12-percent increase in the annual rate of prices accounted for most of the growth in expenditures. Population decreased at an annual rate of 1 percent because of a slight decrease in the number of supplemental security income recipients, but utilization increased 2 percent because of a small increase in services.

Era 4, FY 1981-82: Fiscal retrenchment—"Fiscal retrenchment" characterizes the effect on public health programs during this era of such factors as recession, unemployment, and State budget balancing problems. This period was characterized by a stable Medicaid recipient population and no changes in utilization. This was accomplished as State Medicaid programs reduced the growth of expenditures for optional medical services and slowed the growth of medically needy eligibles.

Price (cost of services per recipient) was found to be responsible for virtually all the increases in expenditures in this era. Price rose from a 19-percent contributor to expenditure increases in era 1 to a 92-percent contributor in era 4. Long-term care continued to be the main contributor to the growth of expenditures (Figure 2.6). In FY 1973, long-term care expenditures accounted for approximately one-third of all Medicaid expenditures; by FY 1982, they were nearly one-half. As the size of the aged population increases, this trend can be expected to continue.

3. Medicare: Description and data

This chapter presents detailed information on the Medicare program. The Medicare program for financing health care for the aged was enacted on July 30, 1965, as Title XVIII of the Social Security Act. Benefits began on July 1, 1966. The program (Health Insurance for the Aged) was substantially expanded by the 1972 amendments to the Social Security Act (Public Law 92-603). These amendments, effective July 1, 1973, extended Medicare coverage to disabled beneficiaries of the social security and railroad retirement programs and to persons requiring dialysis or a kidney transplant for end-stage renal disease. The official name of the Medicare program was then changed to Health Insurance for the Aged and Disabled. This report deals with major changes in the Medicare law through the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248), which became law on September 3, 1982, and the Social Security Amendments of 1983 (Public Law 98-21), effective October 1, 1983.

The Secretary of the Department of Health and Human Services (DHHS) has overall responsibility for the Medicare program. Within DHHS, the Health Care Financing Administration (HCFA) administers Medicare. Medicare consists of two separate but complementary insurance programs: hospital insurance (HI) and supplementary medical insurance (SMI). HI covers inpatient hospital and skilled nursing facility services, and SMI covers physicians' and related services for eligible persons who voluntarily pay premiums or whose premiums are paid for them.

The next sections describe eligibility standards, benefits, financing, and administration of HI and SMI. Analysis of the distribution of benefits is presented according to the following formula:

$$\frac{\textit{Persons served}}{\textit{Enrollees}} \times \frac{\textit{Reimbursements}}{\textit{Persons served}} = \frac{\textit{Rembursements}}{\textit{Enrollees}}$$

Where

- Persons served are persons who exceeded HI or SMI deductibles and were reimbursed by Medicare for services received;
- Persons served/enrollees is the proportion of enrollees who exceeded deductibles and were reimbursed for covered services;
- Reimbursements/persons served is the average Medicare reimbursement for persons who received Medicare reimbursements;
- Reimbursements/enrollees is the average Medicare reimbursement for a population group.

In the final sections of this chapter, the Medicare program's arrangements with group practice prepayment plans and health maintenance organizations are discussed and the Medicare statistical systems is described.

Eligibility

All persons 65 years of age or over who are entitled to monthly social security cash benefits or payments from the railroad retirement system are eligible for benefits under the HI program. Disabled people entitled for at least 24 months to cash benefits under the social security or railroad retirement system are also eligible for HI benefits. A person must be disabled for 5 months before disability benefits begin. Thus, Medicare coverage begins the 30th month after the first full month of disability.

Medicare coverage for the disabled began on July 1, 1973. The Social Security Amendments of 1980 (Public Law 96-265), effective December 1, 1980, removed an earlier requirement that the months of disability payments needed to establish eligibility be consecutive.

HI protection also extends to persons who have end-stage renal disease (ESRD) and who require renal dialysis or a kidney transplant, as long as they are currently insured, entitled to monthly social security benefits, or the spouses or dependent children of such insured persons. Eligibility for coverage begins the third month after renal dialysis treatments begin, or before this qualifying dialysis period for ESRD enrollees who receive kidney transplants without starting or receiving dialysis in preparation for transplantation. Eligibility ends with the 36th month after a person receives a kidney transplant or after dialysis treatment has been terminated.

The 1972 Amendments, effective July 1973, permit most persons 65 years and over who are ineligible for HI coverage to enroll voluntarily by paying a monthly premium. This "premium-HI," set at $155 a month for 1984, represents the full premium cost of HI. Prior to the 1982 TEFRA, the 12-month adjustment period had ended in June, but since 1983 the end of the period had been December, and the premium-HI is adjusted for each calendar year.

To obtain "premium-HI," enrollees are required by law to also obtain SMI coverage. The Omnibus Budget Reconciliation Acts of 1980 and 1981 made the premium-HI enrollment procedure the same as the SMI procedure (discussed later). As a result, effective April 1981, aged enrollees may terminate and reenroll in HI an unlimited number of times. However, they may enroll or reenroll only during January through March of each year. In addition, the 1982 TEFRA extended Medicare coverage to Federal employees and required them to pay for HI.

Persons entitled to benefits under the HI program and most other persons age 65 or over may voluntarily enroll in SMI. Only the aged can enroll in SMI without being eligible for HI; disabled persons may not. The Omnibus Budget Reconciliation Act of 1981, effective October 1, 1981, repealed SMI continuous open enrollment and reinstated the general enrollment period, which occurs January through March of each year. Coverage becomes effective July 1. Persons may terminate SMI enrollment by not paying premiums. A person may reenroll, but coverage will not begin again until July 1. (To do so, an individual must pay a surcharge of 10 percent for every 12 months that he or she could have been enrolled.) Under the buy-in system, a State government may enroll and pay SMI premiums for eligible aged and disabled individuals who are also covered by the Medicaid program.

Data on the total number of aged and disabled persons enrolled in Medicare (HI and/or SMI) in 1980 and 1981 are shown in Table 3.1. Total Medicare enrollees, 90 percent of whom were aged, numbered 29.0 million in 1981. More than 98 percent were enrolled in both HI and SMI or in HI only. The remainder, 420,000 aged who were ineligible for HI, were enrolled only in SMI. Ninety-two percent of disabled HI enrollees were also enrolled in SMI.

The number of aged and disabled enrollees for both HI and SMI are shown in Table 3.2 by region and division. For both aged and disabled groups, the greatest number of enrollees live in the South, and the smallest number live in the West. Detailed information on the distribution of HI and SMI benefits for aged and disabled enrollees is presented in Tables 3.3 and 3.4. Much larger proportions of aged and disabled enrollees received SMI benefits than HI benefits. For both groups, average reimbursements per person served were far higher for HI than for SMI. Also for both groups, the proportions receiving benefits (persons served per 1,000 enrollees) were higher for older age groups among both HI and SMI enrollees.

Table 3.1

Number of aged and disabled Medicare enrollees, by type of coverage: July 1, 1980 and 1981

Type of enrollee	Hospital insurance and/or supplementary medical insurance		Hospital insurance		Supplementary medical insurance	
	July 1, 1980	July 1, 1981	July 1, 1980	July 1, 1981	July 1, 1980	July 1, 1981
	Number in thousands					
Total	28,478.2	29,010.0	28,066.9	28,589.5	27,399.7	27,941.2
Aged[1]	25,515.1	26,011.0	25,103.7	25,590.6	24,680.4	25,181.7
Disabled[2]	2,963.2	2,999.0	2,963.2	2,999.0	2,719.2	2,759.5

[1] All enrollees 65 years of age and over, including enrollees with end-stage renal disease (ESRD).
[2] All enrollees under 65 years of age, including enrollees with ESRD.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management, Health Care Financing Administration. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.2

Number of Medicare enrollees, by type of coverage, type of enrollee, census region, and census division: July 1, 1981

Census region and division	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Total	Aged	Disabled[1]	Total	Aged	Disabled[1]	Total	Aged	Disabled[1]
All areas	29,009,934	26,010,978	2,998,956	28,589,504	25,590,555	2,998,949	27,941,227	25,181,731	2,759,496
United States[2]	28,410,401	25,516,716	2,893,685	27,991,143	25,097,465	2,893,678	27,671,752	24,960,176	2,711,576
Northeast	6,716,586	6,078,731	637,855	6,629,415	5,991,563	637,852	6,555,405	5,961,356	594,049
New England	1,672,414	1,530,568	141,846	1,653,412	1,511,566	141,846	1,631,099	1,501,323	129,776
Middle Atlantic	5,044,172	4,548,163	496,009	4,976,003	4,479,997	496,006	4,924,306	4,460,033	464,273
North Central	7,431,761	6,757,923	673,838	7,358,340	6,684,503	673,837	7,262,083	6,633,535	628,548
East North Central	5,035,363	4,544,082	491,281	4,981,560	4,490,279	491,281	4,918,068	4,459,834	458,234
West North Central	2,396,398	2,213,841	182,557	2,376,780	2,194,224	182,556	2,344,015	2,173,701	170,314
South	9,432,326	8,336,098	1,096,228	9,248,347	8,152,121	1,096,226	9,165,148	8,132,178	1,032,970
South Atlantic	4,849,068	4,292,485	556,583	4,757,158	4,200,575	556,583	4,714,603	4,190,406	524,197
East South Central	1,890,285	1,639,082	251,203	1,846,850	1,595,648	251,202	1,840,878	1,601,883	238,995
West South Central	2,692,973	2,404,531	288,442	2,644,339	2,355,898	288,441	2,609,667	2,339,889	269,778
West	4,801,988	4,319,779	482,209	4,729,168	4,246,960	482,208	4,666,426	4,213,604	452,822
Mountain	1,196,418	1,082,527	113,891	1,182,828	1,068,937	113,891	1,155,585	1,050,442	105,143
Pacific	3,605,570	3,237,252	368,318	3,546,340	3,178,023	368,317	3,510,841	3,163,162	347,679

[1] Includes disabled enrollees under age 65 with end-stage renal disease and enrollees with end-stage renal disease only.
[2] Includes 50 States, District of Columbia, and unknown residence.

NOTE: This table is based on data recorded in the Medicare health insurance master file on March 30, 1982.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.3

Persons served and reimbursements for aged Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1981

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	655.0	$2,024	$1,326	243.4	$3,877	$944	669.5	$613	$410
Age									
65-69 years	595.5	1,693	1,008	187.3	3,653	684	610.5	570	348
70-74 years	641.1	1,924	1,233	222.9	3,845	857	652.5	624	407
75-79 years	688.1	2,142	1,474	267.0	3,961	1,058	699.1	643	450
80-84 years	723.2	2,396	1,733	315.6	4,049	1,278	737.9	641	473
85 years or over	746.3	2,507	1,871	352.5	4,021	1,417	775.9	619	480
Sex									
Male	624.3	2,272	1,418	254.8	3,946	1,005	640.0	688	440
Female	675.6	1,871	1,264	235.7	3,827	902	689.0	567	391
Race									
White	661.0	2,010	1,329	246.1	3,821	940	673.7	611	412
All other	599.2	2,348	1,347	221.5	4,566	1,011	627.4	645	405
Census region									
Northeast	702.3	2,046	1,437	229.0	4,404	1,009	711.3	634	451
North Central	641.2	2,135	1,369	258.0	3,963	1,022	646.9	564	365
South	641.7	1,875	1,203	262.4	3,264	856	650.9	576	375
West	691.3	2,132	1,474	223.7	4,444	994	698.8	728	509

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981*. HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.4

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1981

Characteristic	Hospital insurance and/or supplementary medical insurance			Hospital insurance			Supplementary medical insurance		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	615.2	$2,881	$1,772	251.4	$4,400	$1,106	655.9	$1,104	$724
Age									
Under 35 years	515.6	3,413	1,760	192.9	5,206	1,004	547.9	1,499	821
35-44 years	549.1	3,013	1,654	213.9	4,532	969	588.1	1,273	749
45-54 years	592.4	2,940	1,742	249.6	4,258	1,063	638.1	1,169	746
55-59 years	618.3	2,812	1,739	259.3	4,303	1,116	662.5	1,026	680
60-64 years	697.8	2,683	1,872	286.9	4,284	1,229	735.2	938	690
Sex									
Male	560.6	2,827	1,585	233.2	4,308	1,005	602.6	1,060	639
Female	709.1	2,954	2,095	282.7	4,532	1,281	744.6	1,164	867
Race									
White	651.2	2,764	1,700	253.1	4,286	1,085	657.4	1,020	671
All other	603.6	3,471	2,095	239.1	4,998	1,195	637.9	1,522	971
Census region									
Northeast	666.4	2,903	1,935	241.6	4,911	1,186	703.3	1,142	803
North Central	625.3	3,105	1,924	269.7	4,791	1,292	657.0	1,059	696
South	592.5	2,668	1,581	271.1	3,652	990	616.7	1,071	627
West	683.1	3,054	2,086	234.5	5,210	1,222	717.1	1,285	921

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981*. HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Benefits

Overview

The HI program covers inpatient hospital care and posthospital care in skilled nursing facilities (SNF's). The program also covers home health agency services for persons confined to the home who need skilled nursing care or physical or speech therapy. To be covered, services must be provided by institutions or organizations that have been certified as qualified providers and have agreements to participate in the program. Exceptions to this rule are made for emergency services.

Prior to the Omnibus Reconciliation Act of 1980, the HI program covered home health visits only if they followed a hospital stay. Home health visits that did not follow a hospital stay were covered by the SMI program. Coverage under HI was limited to 100 visits per benefit period, and under SMI to 100 visits in a calendar year. The 1980 law, effective July 1, 1981, eliminated the HI requirement for prior hospitalization and the limit on visits. Under the new law, all home health visits are covered by the HI program unless a beneficiary has SMI coverage only. In such cases, home health visits are covered by the SMI program.

The SMI program covers a variety of medical services and supplies furnished by physicians and other health care professionals in connection with physicians' services, and it covers outpatient and (for persons not covered by HI) home health services.

Table 3.5 presents counts of the number of institutional providers participating in Medicare in 1982. Most of the Nation's hospitals participated in Medicare, and they were the largest class of participating providers (6,742 hospitals with 1.2 million beds). Hospitals also received the largest share of Medicare's reimbursements.

As shown in Table 3.6, almost all HI reimbursements and 66 percent of total Medicare reimbursements went for hospital inpatient services in 1982. SMI reimbursements accounted for 30 percent of total reimbursements, and 77 percent of SMI reimbursements were for physicians' services. The distribution of reimbursements differed for aged and disabled enrollees. The proportion of reimbursements covered by HI was smaller for disabled enrollees than for the aged, and the proportion covered by SMI was correspondingly larger.

Information on the distribution of specific benefits is shown for aged enrollees in Table 3.7 and for disabled enrollees in Table 3.8. In 1981, the proportion of aged enrollees receiving all listed benefits was successively higher for each age group. By far the largest proportion of the aged received physicians' services, followed by outpatient and then inpatient hospital services. Very small proportions received SNF or home health benefits. The proportion of aged receiving outpatient and home health services was greater for all other races than for white enrollees. For other services, larger proportions of aged white persons received Medicare benefits. With the exception of inpatient hospital benefits, a larger proportion of aged women than men received benefits.

Except for physicians' services, reimbursements per person served were higher for aged enrollees of all other races than for whites (Ruther and Dobson, 1981). Reimbursement per person served among the aged was highest for inpatient hospital services ($3,806), followed by SNF services ($1,486), and home health agency services ($724). Reimbursements per person served for physicians' and outpatient services were $530 and $219, respectively.

Disabled enrollees' reimbursements per person served were higher than those of the aged for every service. Outpatient reimbursements per disabled person served were much higher than those of the aged because a higher proportion of disabled than aged enrollees are ESRD patients.

Among the disabled, smaller proportions of white than all other persons served received home health and outpatient benefits. Reimbursements per person served were higher for persons of all other races for all services. Larger

Table 3.5

Number of facilities participating in Medicare and number of Medicare beds, by type of facility: July 1, 1975-82

Type of facility	1975	1976	1977	1978	1979	1980	1981	1982	Percent change 1975-82
					Number				
Facilities									
Hospitals	6,773	6,802	6,806	6,797	6,801	6,777	6,736	6,742	−.5
Short-stay	6,107	6,112	6,131	6,130	6,128	6,104	6,065	6,070	−.6
Psychiatric	385	401	400	400	411	408	412	419	8.8
Other long-stay	238	251	239	241	244	265	259	253	6.3
Skilled nursing facilities	3,932	3,928	4,002	4,749	4,963	5,052	5,258	5,408	37.5
Home health agencies	2,242	2,361	2,420	2,605	2,788	2,924	3,110	3,415	52.3
Independent laboratories	3,048	3,194	3,221	3,281	3,373	3,447	3,484	3,581	17.5
Beds									
Hospitals	1,140,395	1,149,122	1,162,990	1,142,248	1,147,498	1,149,997	1,147,324	1,150,479	.9
Short-stay	901,757	922,601	953,067	965,323	985,070	990,621	997,020	1,012,490	12.3
Psychiatric	198,802	188,288	172,949	145,376	133,106	131,276	123,527	112,168	−43.6
Other long-stay	33,013	32,479	29,390	27,827	27,069	28,100	26,777	25,821	−21.8
Skilled nursing facilities	287,479	309,790	349,650	418,246	419,835	436,007	457,692	488,495	69.9

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Unpublished data.

Table 3.6

Medicare reimbursements, by type of enrollee, type of coverage, and type of service: Calendar year 1982

Type of coverage and type of service	All enrollees		Aged		Disabled	
	Amount in millions	Percent distribution	Amount in millions	Percent distribution	Amount in millions	Percent distribution
Total	$51,086	100.0	$44,338	100.0	$6,748	100.0
Hospital insurance	35,631	69.7	31,490	71.0	4,141	61.4
Inpatient	33,897	66.4	29,867	67.4	4,030	59.7
Skilled nursing facility	474	.9	457	1.0	17	.3
Home health agency	1,260	2.5	1,166	2.6	94	1.4
Supplementary medical insurance	15,455	30.3	12,980	29.3	2,475	36.7
Physicians'	11,888	23.3	10,461	23.6	1,427	21.1
Outpatient	3,030	5.9	2,043	4.6	987	14.6
Home health agency	19	Z	18	Z	1	Z
Group practice plan	335	.7	295	.7	40	.6
Independent laboratory[1]	183	.4	163	.4	20	.3

[1] Includes only services billed directly by providers.
NOTE: Total, hospital insurance, and supplementary medical insurance reimbursements are actual amounts reported in Medicare trust fund reports. Distributions by service are preliminary estimates.

SOURCE: Health Care Financing Administration, Office of the Actuary: Unpublished data.

Table 3.7

Persons served and reimbursements for aged Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1981

Characteristic	Hospital insurance						Supplementary medical insurance		
	Inpatient hospital services			Skilled nursing facility services			Physicians' and other medical services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	237.3	$3,806	$903	9.5	$1,486	$14	650.5	$530	$345
Age									
65-69 years	184.7	3,611	667	2.6	1,670	4	588.8	488	287
70-74 years	218.8	3,786	828	5.3	1,559	8	634.0	534	339
75-79 years	260.4	3,874	1,009	10.4	1,513	16	682.3	556	379
80-84 years	304.6	3,955	1,205	19.0	1,482	28	721.1	565	407
85 years or over	335.7	3,935	1,321	30.3	1,385	42	757.5	547	414
Sex									
Male	250.0	3,888	972	7.4	1,411	10	620.5	601	373
Female	228.7	3,745	856	10.9	1,521	17	670.4	487	326
Race									
White	240.2	3,749	901	9.9	1,466	15	656.8	533	350
All other	213.4	4,506	962	6.3	1,809	11	588.7	512	301
Census region									
Northeast	220.6	4,344	958	8.9	1,684	15	685.4	544	373
North Central	252.6	3,902	986	10.7	1,559	17	626.2	485	304
South	256.8	3,192	820	7.6	1,341	10	635.5	509	323
West	218.7	4,346	950	13.2	1,367	18	685.3	621	426

See footnotes at end of table.

Table 3.7—Continued

Persons served and reimbursements for aged Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1981

Characteristic	Supplementary medical insurance			Hospital insurance and/or supplementary medical insurance		
	Outpatient services			Home health agency services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee
Total	281.8	$219	$62	41.1	$724	$30
Age						
65-69 years	260.6	226	59	19.4	724	14
70-74 years	276.5	236	65	31.9	729	23
75-79 years	291.5	225	66	48.6	748	36
80-84 years	305.0	196	60	70.3	714	50
85 years or over	321.2	178	57	89.3	703	63
Sex						
Male	273.3	237	65	35.3	716	25
Female	287.4	208	60	44.9	728	33
Race						
White	279.8	209	58	40.3	707	28
All other	304.2	317	96	49.8	860	43
Census region						
Northeast	339.2	219	74	56.1	694	39
North Central	287.9	203	58	35.1	635	22
South	236.4	199	47	37.9	798	30
West	286.6	281	81	37.0	756	28

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.8

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1981

Characteristic	Hospital insurance						Supplementary medical insurance		
	Inpatient hospital services			Skilled nursing facility services			Physicians' and other medical services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee		Per person served	Per enrollee
Total	246.4	$4,389	$1,081	2.8	$1,693	$5	622.4	$698	$434
Age									
Under 35 years	190.0	5,217	991	1.0	1,949	2	504.2	759	383
35-44 years	209.9	4,538	953	1.4	1,697	2	550.9	712	392
45-54 years	244.9	4,254	1,042	1.9	1,776	3	605.4	715	433
55-59 years	254.0	4,285	1,088	2.8	1,794	5	632.2	697	441
60-64 years	280.5	4,261	1,195	4.6	1,603	7	704.7	667	470
Sex									
Male	229.0	4,305	986	2.2	1,712	4	567.4	689	391
Female	276.3	4,509	1,246	3.7	1,674	6	713.9	711	508
Race									
White	248.3	4,273	1,061	2.8	1,637	5	628.1	693	435
All other	233.3	5,002	1,167	2.2	2,075	5	584.8	729	426
Census region									
Northeast	234.5	4,910	1,151	2.7	1,941	5	656.3	705	463
North Central	264.8	4,793	1,269	3.4	1,761	6	622.5	669	416
South	266.8	3,635	970	2.1	1,476	3	588.1	662	389
West	230.4	5,190	1,196	3.9	1,671	7	689.9	808	557

See footnotes at end of table.

Table 3.8—Continued

Persons served and reimbursements for disabled Medicare enrollees, by type of coverage and demographic characteristics: Calendar year 1981

Characteristic	Supplementary medical insurance			Hospital insurance and/or supplementary medical insurance		
	Outpatient services			Home health agency services		
	Persons served per 1,000 enrollees	Reimbursements		Persons served per 1,000 enrollees	Reimbursements	
		Per person served	Per enrollee		Per person served	Per enrollee
Total	353.4	$811	$287	27.1	$837	$23
Age						
Under 35 years	343.3	1,272	437	13.5	965	13
35-44 years	351.2	1,077	354	18.1	938	17
45-54 years	358.3	866	310	23.1	859	20
55-59 years	348.5	680	237	29.4	836	25
60-64 years	358.3	604	216	37.6	788	30
Sex						
Male	320.1	768	246	21.2	792	17
Female	408.8	869	355	37.2	880	33
Race						
White	344.1	676	233	26.3	833	22
All other	395.5	1,369	541	30.4	856	26
Census region						
Northeast	412.3	816	336	39.4	857	34
North Central	362.7	763	277	26.0	750	20
South	307.1	766	235	22.9	857	20
West	392.2	921	361	24.8	860	21

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U.S. Government Printing Office, Aug. 1983.

proportions of disabled women than men received all types of benefits. Except for SNF services, reimbursements per person served were also consistently higher for disabled women than for men.

Hospital insurance

The law governing the hospital insurance (HI) program limits coverage to a "benefit period" (or "spell of illness"). A benefit period begins with an enrollee's first day of hospitalization and ends when the enrollee has not been a bed patient in a hospital or skilled nursing facility for at least 60 consecutive days. Although there is no limit to the number of benefit periods that an enrollee may have, there are limits on the number of days covered. HI covers up to 90 days of service in a participating hospital during a single benefit period.

After an initial deductible, applicable to each benefit period, the patient is entitled to 60 days of hospitalization with no additional cost sharing. From the 61st through the 90th day of the benefit period, the patient is responsible for coinsurance ($89 per day in 1984) equal to one-fourth of the deductible. The Secretary of DHHS is required to determine the deductible amount each year, using a formula specified by law. The formula is based on the average per diem rate for inpatient services during the preceding calendar year. Reflecting increases in hospital costs, the deductible has risen from $40 in 1966 to $356 in 1984.

HI enrollees also have a "lifetime reserve" of 60 additional hospital days which can be used at their option when the 90 days covered in a benefit period have been exhausted. Lifetime reserve days require a coinsurance equal to one-half the deductible ($178 for each lifetime reserve day in 1984).

The HI program also pays nonparticipating hospitals for emergency services. Hospitals may bill the program annually for all emergency services rendered. If this arrangement is unacceptable to the provider, the patient must pay for services received and submit a claim for reimbursement. Reimbursements are made according to a specified level and are subject to a deductible and coinsurance.

Hospital services covered under HI include room and board in "semiprivate" accommodations containing from two to four beds. Private accommodations are covered if medically necessary; otherwise, the patient must pay a special charge to the hospital. Nursing services (except private-duty nursing), drugs and biologicals, and other services ordinarily furnished by a hospital to its inpatients are also covered. The HI program covers the services of interns and resident physicians in approved teaching programs. Other physicians' services, including those of hospital-based specialists such as radiologists, anesthesiologists, and pathologists, are covered under SMI. Hospital benefits also include reimbursement for inpatient services provided by tuberculosis and psychiatric hospitals. There is a 190-day lifetime limit for psychiatric hospitals.

Prior to the Social Security Amendments of 1983 (Public Law 98-21), effective October 1, 1983, the HI program paid hospitals the "reasonable costs" of providing services to Medicare beneficiaries. Reasonable costs are determined after services have been delivered and are

based on program regulations. The Medicare law and regulations specify the kinds of hospital costs allowed. For example, Medicare does not cover private-duty nursing or costs unrelated to patient care. Once a hospital's total allowable costs are determined, Medicare apportions the cost between Medicare patients and other patients. Medicare then pays allowable costs based on services received by Medicare patients.

The Social Security Amendments of 1983 established prospective payments for Medicare inpatient hospital services that drastically changed the way hospitals are paid. This legislation reforms the retrospective, cost-based reimbursement system for inpatient care through which payments are made for "reasonable costs" incurred during the preceding year. The new prospective payment system establishes one price for each of 467 diagnosis-related groups. Prices are established in advance for the coming year, and hospitals are paid these prices regardless of the costs they actually incur. It is hoped that the prospective payment system will provide incentives for hospitals to control costs. The prospective payment system is being phased in over a 3-year period beginning October 1983.

TEFRA of 1982 provided a new HI benefit, hospice care for the terminally ill. This benefit has been authorized by Congress for 3 years beginning November 1, 1983. Medicare patients who qualify can receive a full range of medical and support services for their condition while continuing to live in their own homes or other settings outside of the hospital. Hospice care is a comprehensive home-care program for the terminally ill. Medicare-covered services include physician services, nursing care, medical appliances and supplies, outpatient drugs for symptom management and pain relief, home health aide and homemaker services, medical social services, and counseling.

To qualify for hospice benefits, patients must have HI coverage. Their doctor and the hospice medical director must certify that they have a terminal illness; patients must choose hospice care instead of the standard Medicare benefits; and they receive care from a Medicare-certified hospice program.

Medically necessary services for conditions not related to the terminal illness continue to be covered by Medicare. Medicare hospice patients do not pay deductibles and pay copayments for only two items: a $5 maximum for each outpatient prescription for drugs and medications to manage symptoms and relieve pain and 5 percent of the cost of an inpatient hospice stay for respite care. Respite care is a special benefit to provide temporary relief to family members or others who regularly care for the patient at home. Special benefit periods apply to hospice care. A patient can receive respite care for two periods of 90 days each and one of 30 days.

Since HI covers the full cost of medical and support services for a terminal condition, the patient choosing hospice care cannot be paid the standard Medicare benefits for the terminal illness. Medically necessary services for conditions other than the terminal illness will continue to be covered as standard Medicare benefits. If the patient's attending physician does not work for the hospice, SMI will pay 80 percent of allowed charges after the deductible for physicians' services is met.

Tables 3.9, 3.10, and 3.11 present data on the use of and reimbursements for inpatient hospital services. In 1980, there were 10.4 million Medicare inpatient hospital discharges (Table 3.9). These discharges resulted in reimbursements of $22.2 billion for 108 million covered days of care. Short-stay hospital care accounted for nearly 99 percent of all discharges and reimbursements and over 97

Table 3.9

Use of and reimbursements for inpatient hospitals by Medicare enrollees, by type of enrollee and type of hospital: Calendar year 1980

Type of enrollee and type of hospital	Discharges		Covered days of care			Reimbursements			
	Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
All enrollees									
All hospitals	10,405	371	108,356	10.4	3,861	$22,170	$2,131	$205	$790
Short-stay	10,296	367	105,805	10.3	3,770	21,878	2,125	207	779
Long-stay	109	4	2,551	23.4	91	292	2,679	114	10
Psychiatric	68	2	1,579	23.2	56	140	2,059	89	5
All other	41	1	972	23.7	35	152	3,707	156	5
Aged									
All hospitals	9,130	364	95,345	10.4	3,798	19,470	2,133	204	776
Short-stay	9,068	361	93,845	10.3	3,738	19,281	2,126	205	768
Long-stay	62	2	1,500	24.2	60	189	3,048	126	8
Psychiatric	29	1	695	24.0	28	65	2,241	94	3
All other	33	1	805	24.4	32	124	3,758	154	5
Disabled									
All hospitals	1,275	430	13,012	10.2	4,391	2,699	2,117	207	911
Short-stay	1,228	414	11,960	9.7	4,036	2,597	2,115	217	876
Long-stay	47	16	1,052	22.4	355	102	2,170	97	34
Psychiatric	39	13	885	22.7	299	74	1,897	84	25
All other	8	3	167	20.9	56	28	3,500	168	9

NOTE: Only inpatient services are included.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Medicare provider analysis and review, Inpatient Hospital Stay Record File, unpublished data.

percent of covered days of care. Aged enrollees, who represented 89 percent of all HI enrollees, used 88 percent of all covered days of care. Discharges per 1,000 enrollees, covered days of care per 1,000 enrollees, and average reimbursements per enrollee were lower for the aged than the disabled.

Tables 3.10 and 3.11 present data on the use of short-stay hospitals by aged and disabled enrollees, respectively. For both these groups, discharges per 1,000 enrollees and covered days of care per 1,000 increased with age. Among the aged, the discharge rate for men exceeded that for women. The opposite was true for disabled enrollees. The discharge rate for both aged and disabled white persons exceeded that for persons of all other races. However, aged and disabled enrollees of other races had longer average lengths of stay and higher reimbursements per discharge and per covered days of care than white enrollees.

By region, the South had the highest discharge rate but the lowest reimbursements per discharge and per covered day of care for both aged and disabled enrollees. Aged enrollees in the Northeast had the lowest discharge rate and the highest reimbursements per discharge. For both aged and disabled enrollees, the West had the highest reimbursements per covered day of care but the lowest number of covered days of care per discharge. (For further discussion of geographic differences, see Gornick, 1982.)

HI also covers services in participating skilled nursing facilities for up to 100 days in a benefit period. For the first 20 days, patients pay no coinsurance. The remaining 80 days require a coinsurance equal to one-eighth of the inpatient deductible ($44.50 in 1984). A beneficiary is eligible for SNF benefits only after hospitalization for at least 3 consecutive days and only if the transfer to an SNF occurs within 30 days after hospital discharge. (The 1980 legislation increased the period to 30 days from 14 days.)

Data on the use of SNF's by aged and disabled enrollees in 1981 are reported in Tables 3.12 and 3.13. Information on persons served and reimbursements is shown by age, sex, race, and region. Overall, the proportion of the elderly who received SNF benefits was much higher than that of the disabled — 9.5 persons served per 1,000 aged enrollees, compared with 2.8 per 1,000 disabled enrollees. However, reimbursements per person served were 14 percent higher for the disabled than the aged.

Among both aged and disabled enrollees, the number of persons served and total reimbursements increased with age, but reimbursements per person served generally decreased with age. Among both the aged and the disabled, higher proportions of females than males received SNF benefits, and rates per 1,000 enrollees were much higher for white persons than for persons of all other races. However, reimbursements per person served were much higher for all others than for white persons. The number of persons served per 1,000 aged and disabled enrollees was lowest in the South and highest in the West, but reimbursements per person served were lowest in the South and West.

The third type of benefit covered by HI is home health agency (HHA) services for persons confined to the

Table 3.10

Use of and reimbursements for short-stay hospitals by aged Medicare enrollees, by demographic characteristics: Calendar year 1980

Characteristic	Aged hospital insurance enrollees in thousands	Discharges		Covered days of care			Reimbursements			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	25,104	9,068	361	93,845	10.4	3,738	$19,281	$2,128	$205	$768
Age										
65-66 years	3,513	927	264	8,644	9.3	2,461	1,849	1,997	214	526
67-68 years	3,269	927	284	8,828	9.5	2,701	1,881	2,032	213	575
69-70 years	2,983	911	305	8,874	9.7	2,975	1,870	2,056	210	627
71-72 years	2,732	901	330	8,916	9.9	3,264	1,868	2,076	209	684
73-74 years	2,395	861	359	8,795	10.2	3,672	1,824	2,121	207	762
75-79 years	4,731	1,908	403	20,136	10.6	4,256	4,119	2,161	204	871
80-84 years	3,072	1,423	463	15,717	11.1	5,116	3,143	2,212	200	1,023
85 years or over	2,407	1,212	504	13,935	11.5	5,789	2,727	2,253	195	1,133
Sex										
Male	10,156	3,970	391	39,721	10.0	3,911	8,407	2,120	211	828
Female	14,948	5,098	341	54,124	10.6	3,621	10,874	2,135	201	727
Race										
White	22,244	8,146	366	83,324	10.2	3,746	17,053	2,096	204	767
All other	2,160	693	321	8,126	11.7	3,762	1,739	2,513	214	805
Census region										
Northeast	5,915	1,914	324	23,636	12.4	3,996	4,816	2,518	203	814
North Central	6,576	2,536	386	26,898	10.6	4,090	5,489	2,167	204	835
South	7,974	3,175	398	30,811	9.7	3,864	5,557	1,752	180	697
West	4,132	1,383	335	11,904	8.6	2,881	3,362	2,433	282	814

NOTE: Only inpatient services are included.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Medicare provider analysis and review, Inpatient Hospital Stay Record File, unpublished data.

home and needing part-time or intermittent skilled nursing care or therapy. Covered services include skilled nursing care; physical, occupational, and speech therapy; part-time or intermittent services of a home health aide; medical supplies other than drugs and biologicals; use of medical appliances; and, in certain cases, services of an intern or resident. Services must be furnished by an approved HHA.

Table 3.11

Use of and reimbursements for short-stay hospitals by disabled Medicare enrollees, by demographic characteristics: Calendar year 1980

Characteristic	Disabled hospital insurance enrollees in thousands	Discharges		Covered days of care			Reimbursements			
		Number in thousands	Per 1,000 enrollees	Number in thousands	Per discharge	Per 1,000 enrollees	Amount in millions	Per discharge	Per covered day of care	Per enrollee
Total	2,963	1,228	414	11,960	9.7	4,036	$2,597	$2,115	$217	$876
Age										
Under 35 years	371	120	323	1,199	10.0	3,232	285	2,383	238	768
35-44 years	369	134	363	1,252	9.4	3,393	278	2,081	222	753
45-54 years	657	278	423	2,604	9.4	3,963	562	2,024	216	855
55-59 years	649	279	430	2,717	9.8	4,186	581	2,086	213	895
60-64 years	916	418	456	4,187	10.0	4,571	891	2,135	213	973
Sex										
Male	1,871	715	382	6,781	9.5	3,624	1,485	2,081	219	794
Female	1,093	514	470	5,178	10.1	4,737	1,112	2,167	214	1,017
Race										
White	2,422	1,023	422	9,796	9.6	4,045	2,097	2,053	214	866
All other	487	181	372	1,913	10.6	3,928	446	2,473	233	916
Census Region										
Northeast	634	240	379	2,769	11.5	4,368	591	2,463	213	932
North Central	666	297	446	3,076	10.4	4,619	684	2,307	222	1,027
South	1,079	487	451	4,413	9.1	4,090	831	1,709	188	770
West	479	193	403	1,604	8.3	3,349	477	2,473	297	996

NOTE: Only inpatient services are included.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Medicare provider analysis and review, Inpatient Hospital Stay Record File, unpublished data.

Table 3.12

Use of skilled nursing facilities by aged Medicare enrollees, by demographic characteristics: Calendar year 1981

Characteristic	Aged hospital insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	25,590.6	242.8	9.5	$361.0	$1,486	$14.11
Age						
65-69 years	8,423.4	21.7	2.6	36.2	1,670	4.30
70-74 years	6,728.6	35.8	5.3	55.8	1,559	8.29
75-79 years	4,830.1	50.5	10.4	76.3	1,513	15.80
80-84 years	3,103.1	59.0	19.0	87.5	1,482	28.20
85 years or over	2,505.3	75.9	30.3	105.1	1,385	41.95
Sex						
Male	10,340.4	76.4	7.4	107.8	1,411	10.43
Female	15,250.2	166.4	10.9	253.1	1,521	16.60
Race[2]						
White	22,661.3	223.3	9.9	327.4	1,466	14.45
All other	2,210.1	14.0	6.3	25.3	1,809	11.45
Census region						
Northeast	5,991.6	53.3	8.9	89.7	1,684	14.97
North Central	6,684.5	71.6	10.7	111.6	1,559	16.70
South	8,152.1	61.6	7.6	82.6	1,341	10.13
West	4,247.0	55.9	13.2	76.4	1,367	17.99

[1] As of July 1, 1981.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.13

Use of skilled nursing facilities by disabled Medicare enrollees, by demographic characteristics: Calendar year 1981

Characteristic	Disabled hospital insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,998.9	8.3	2.8	$14.0	$1,693	$4.67
Age						
Under 35 years	383.5	0.4	1.0	0.7	1,949	1.83
35-44 years	385.1	0.5	1.4	0.9	1,697	2.34
45-54 years	654.7	1.2	1.9	2.2	1,776	3.36
55-59 years	646.8	1.8	2.8	3.3	1,794	5.09
60-64 years	926.8	4.3	4.6	6.9	1,603	7.45
Sex						
Male	1,896.0	4.2	2.2	7.2	1,712	3.80
Female	1,102.9	4.1	3.7	6.8	1,674	6.17
Race[2]						
White	2,442.1	6.9	2.8	11.3	1,637	4.63
All other	499.9	1.1	2.2	2.3	2,075	4.60
Census region						
Northeast	637.9	1.7	2.7	3.3	1,941	5.17
North Central	673.8	2.3	3.4	4.1	1,761	6.09
South	1,096.2	2.3	2.1	3.4	1,476	3.10
West	482.2	1.9	3.9	3.2	1,671	6.64

[1] As of July 1, 1981.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.14

Visits, charges, and reimbursements for home health agency services, by type of Medicare enrollee, sex, and race: Calendar year 1981

Type of enrollee, sex, and race	Visits		Charges			Reimbursements		
	Number in millions	Per 1,000 enrollees	Amount in millions	Amount in millions for visits[1]	Amount per visit[1]	Amount in millions	Per visit	Per enrollee
Total[2]	24.4	841	$925.1	$884.4	$36.25	$801.3	$32.81	$27.62
Type of enrollee								
Aged	22.5	865	850.3	813.6	36.20	736.6	32.77	28.32
Disabled	1.9	634	74.9	70.8	36.47	64.7	33.30	21.57
Sex								
Male	8.6	697	330.7	313.5	36.45	284.4	33.22	23.03
Female	15.9	955	594.5	570.9	35.91	516.9	32.59	31.03
Race								
White	20.9	823	779.4	746.1	35.70	678.5	32.53	27.62
All other	3.0	1,067	122.6	116.4	38.80	102.8	34.82	36.56

[1] Excludes durable medical equipment and supplies, except for drugs and biologicals, furnished by home health agencies.
[2] Includes unknown race.

SOURCE: Health Care Financing Administration, Office of Statistics and Data Management: Unpublished data.

Data on the use of HHA services in 1981 under both HI and SMI are presented in Table 3.14. The number of HHA visits per 1,000 enrollees was 36 percent greater for the aged than for the disabled. Since reimbursements per visit were similar for both groups, reimbursements per enrollee were 31 percent higher for the aged, $28, than the disabled, $22. Females and races other than white had higher proportions of visits per 1,000 enrollees and reimbursements per enrollee than males and white persons, respectively.

Supplementary medical insurance (SMI)

The SMI program covers physicians' services, including visits to the home, office, hospital, and other institutions. The program also pays for other services and supplies, such as drugs and biologicals that cannot be self-administered, if they are furnished as a part of a physician's professional services; diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy; splints, casts, and

other devices used for reduction of fractures and dislocations; purchase or rental of durable medical equipment; ambulance services; and prosthetic devices that replace all or part of a body organ. In addition, SMI pays for outpatient services received in hospitals, rural health centers, community health centers, and renal dialysis centers; and outpatient rehabilitation, speech therapy, and physical therapy services. (The 1972 amendments, effective July 1, 1973, provide for coverage of the services of physical therapists in independent practice furnished in their office or the patient's home if services are under a physician's plan. The reimbursement limit for these services was increased from $100 to $500 by the 1980 Omnibus Budget Reconciliation Act.) Lastly, limited chiropractic and optometric services are also covered.

During each calendar year, enrollees must exceed the SMI deductible to be reimbursed. From 1973 through 1981, the annual deductible was $60 of reasonable charges; beginning in 1982, it was increased to $75. Until October 1981, medical expenses incurred in the last three months of a year were "carried over" to the following year's deductible. The "carryover" provision was eliminated by the 1981 Act for expenses incurred beginning October 1981.

After the deductible is met, SMI pays 80 percent of the reasonable (allowed) charges for covered physicians' services and most other medical services. The reasonable charge is determined for each specific service and is the lowest of:

- The physician's actual charge for the service.
- The physician's customary charge for a service (the physician's 50th percentile charge level for a specific type of service).
- The prevailing charge, set at the 75th percentile of customary charges for the service charged by physicians in an area defined by the carrier.

Increases in the prevailing charge are limited by the Medicare Economic Index (mandated by the Social Security Amendments of 1972). The percent increase in the Index is the maximum allowable increase in the prevailing charge for a physician's service. This percentage is based on the weighted averages of changes in general earnings levels and changes in expenses incurred by physicians in office practice.

Physicians can accept or reject assignment on each claim for payment. Accepting assignment means that the physician submits the bill to the carrier and agrees to accept the reasonable charge. Medicare reimburses 80 percent of the reasonable charge. The patient is responsible for the deductible and the remaining 20 percent of the reasonable charge. The physician who does not accept assignment bills the patient, who is responsible for the total charge. The patient submits the bill to the carrier, and the carrier pays the patient 80 percent of the reasonable charge after the deductible is met.

The charges of independent laboratories accepting assignment are paid at 100 percent of the rate negotiated between DHHS and the specific laboratory, with no deductible and coinsurance requirements. Outpatient hospital services are subject to the SMI deductible and coinsurance, but, like hospital services, are reimbursed for reasonable costs. Outpatient treatment for mental illness is also subject to the deductible and coinsurance; benefits are limited to 50 percent of reasonable charges or $250, which ever is less.

Table 3.15 reports SMI data on average charges and reimbursement rates per enrollee. Data for 1967-81 are presented by type of enrollee. Reimbursements are estimated by subtracting deductible and coinsurance amounts from reasonable costs or charges for each enrollee. Charges exceeding the reasonable charge limits are excluded.

In 1967, the program reimbursed only 57 percent of reasonable costs or charges to aged enrollees; reasonable costs or charges were $109.36 per enrollee and reimbursements were $62.40 per enrollee. During the period 1967-81, reasonable charges per enrollee rose 400 percent, but the SMI deductible rose only 20 percent (from $50 to $60 a year). Because the deductible became smaller in relation to reasonable charges, reimbursements as a percent of reasonable charges increased. In 1974 (the first full year of coverage for the disabled), Medicare reimbursed 67 percent of reasonable costs or charges to the disabled. Reasonable costs or charges were $174.36 per disabled enrollee, and reimbursements were $117.60 per enrollee. By 1981, reasonable costs or charges for the aged and disabled combined had risen to $546 per enrollee, and reimbursements to $408 per enrollee. Medicare SMI reimbursements paid 75 percent of the reasonable costs or charges of all covered services for both aged and disabled enrollees in 1981.

Physicians' services for the aged and disabled combined were the major share, 74 percent, of SMI reimbursements in 1981. Before October 1, 1982, inpatient radiology and pathology services were reimbursed at 100 percent of reasonable charges to physicians accepting assignment. The 1982 TEFRA changed payments for such services to 80 percent of reasonable charges after the SMI deductible is met. Home health agency services had higher than average reimbursement proportions because Medicare pays 100 percent of reasonable costs for these services after the deductible is met. The 1972 Social Security Amendments eliminated coinsurance payments for home health services under SMI.

Data on physicians' and other medical services used in 1981 by aged and disabled enrollees are shown in Tables 3.16 and 3.17. The number of persons served per 1,000 enrollees was 5 percent higher for aged enrollees (651) than for disabled enrollees (622). However, reimbursement per person served was 32 percent higher for disabled enrollees ($698 compared with $530 for the aged). As a result, reimbursements per enrollee were 26 percent higher for disabled than for aged enrollees.

For physicians' services, the number of persons served per 1,000 enrollees was higher for older age groups among both the aged and the disabled. With the exception of the oldest age group, reimbursement per person served for aged enrollees increased with age. The reverse was true for disabled enrollees. Proportionately more women than men received benefits in both enrollee groups, although reimbursement per person served was 23 percent higher for aged men than for aged women. Among the disabled, average reimbursements per person served were similar for both sexes. The number of persons served per 1,000 enrollees was higher for white persons than for persons other than white in both enrollment groups.

Table 3.15

Average reasonable charge and reimbursement per enrollee for supplementary medical insurance, by type of enrollee and type of service: Years ending June 30, 1967-81

Type of enrollee and year	Average enrollment	All services		Physicians' services[1]		Inpatient radiology and pathology services[2]		Outpatient services		Home health agency services		Group practice prepayment plan services		Independent laboratory services	
		Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement	Reasonable cost or charge	Reimbursement
	Number in thousands	Amount													
Aged															
1967	17,750	$109.36	$62.40	$103.44	$59.02	NA	NA	$2.47	$1.41	$1.38	$.79	$1.55	$.88	$.52	$.30
1968	18,038	128.13	80.04	117.21	72.56	$1.89	$1.89	3.88	2.40	2.41	1.49	2.18	1.35	.56	.35
1969	18,833	145.58	93.72	126.11	79.06	6.57	6.57	6.74	4.23	3.06	1.92	2.46	1.54	.64	.40
1970	19,312	154.02	99.90	131.18	82.84	7.14	7.14	9.39	5.93	3.16	2.00	2.39	1.51	.76	.48
1971	19,664	162.57	106.26	137.72	87.80	7.21	7.21	11.86	7.56	2.63	1.68	2.20	1.40	.95	.61
1972	20,043	173.14	114.22	146.82	94.82	6.77	6.77	13.28	8.58	2.49	1.61	2.57	1.66	1.21	.78
1973	20,428	186.56	122.38	157.43	100.95	6.99	6.99	14.73	9.45	3.01	2.17	2.93	1.88	1.47	.94
1974	20,988	204.61	134.37	171.37	109.96	7.44	7.44	17.79	11.42	2.53	2.03	3.60	2.31	1.88	1.21
1975	21,504	237.06	160.20	193.14	127.48	8.72	8.72	23.46	15.48	4.65	3.84	4.60	3.04	2.49	1.64
1976	22,089	272.55	188.55	215.26	145.30	10.89	10.89	31.55	21.30	6.17	5.21	5.68	3.83	3.00	2.02
1977	22,605	313.89	221.31	242.46	167.00	12.21	12.21	41.69	28.72	7.60	6.54	6.33	4.36	3.60	2.48
1978	23,133	355.04	254.21	274.75	192.23	14.75	14.75	47.76	33.42	7.80	6.82	5.81	4.07	4.17	2.92
1979	23,693	399.35	289.31	306.46	217.32	16.33	16.33	57.24	40.59	7.75	6.87	6.90	4.89	4.67	3.31
1980	24,287	463.70	340.63	355.71	256.10	18.70	18.70	65.35	47.05	8.59	7.73	9.75	7.02	5.60	4.03
1981	24,826	543.45	405.04	413.20	301.96	22.92	22.92	78.09	57.07	9.39	8.58	12.45	9.10	7.40	5.41
Disabled[3]															
1974	1,636	174.36	117.60	137.48	90.13	7.54	7.54	21.23	13.92	4.22	3.46	2.89	1.89	1.00	0.66
1975	1,813	215.54	150.14	172.47	117.42	8.40	8.40	25.51	17.37	4.22	3.59	3.38	2.30	1.56	1.06
1976	2,015	251.94	179.56	198.83	138.49	10.03	10.03	31.21	21.74	5.90	5.14	3.86	2.69	2.11	1.47
1977	2,229	305.58	220.98	228.75	161.86	13.02	13.02	51.57	36.49	5.42	4.79	3.99	2.82	2.83	2.00
1978	2,419	351.50	256.58	264.04	188.87	14.22	14.22	59.90	42.85	6.20	5.54	3.50	2.50	3.64	2.60
1979	2,560	408.25	301.74	308.45	223.65	17.08	17.08	69.83	50.63	5.66	5.13	2.85	2.07	4.38	3.18
1980	2,637	485.11	363.38	364.88	268.45	19.79	19.79	82.61	60.78	6.75	6.21	5.87	4.32	5.21	3.83
1981	2,683	571.14	431.89	423.71	314.86	23.13	23.13	102.59	76.24	8.20	7.62	7.10	5.28	6.41	4.76

[1] Figures vary from those in Tables 3.16 and 3.17, as explained in the Note. Also, data in Tables 3.16 and 3.17 are for physicians' and other medical services; these data are for physicians' services only.

[2] Includes services on payment records and under combined billing. These services were reimbursed under hospital insurance before April 1, 1968. Data shown are for April 1968 and later, when combined billings are authorized and these charges reimbursed at 100 percent.

[3] Excludes enrollees with end-stage renal disease only.

NOTE: Figures vary from other tables in this report. These figures are actuarial estimates from a 0.1 percent sample of all aged enrollees and 1.0 percent sample of all disabled enrollees. Reimbursements are estimated by subtracting deductibles and coinsurance amounts from reasonable costs or charges for each enrollee. Charges that exceed amounts the program deems reasonable are excluded.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1983 Annual Report.* Washington. U. S. Government Printing Office, June 28, 1983.

Table 3.16

Use of physicians' and other medical services by aged Medicare enrollees, by demographic characteristics: Calendar year 1981

Characteristic	Aged supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	25,181.7	16,380.3	650.5	$8,688.5	$530.42	$345.03
Age						
65-69 years	8,270.3	4,869.2	588.8	2,375.8	487.92	287.27
70-74 years	6,706.4	4,252.0	634.0	2,272.3	534.40	338.83
75-79 years	4,809.4	3,281.6	682.3	1,824.9	556.12	379.44
80-84 years	3,015.1	2,174.1	721.1	1,228.3	564.95	407.38
85 years or over	2,380.6	1,803.4	757.5	987.2	547.38	414.69
Sex						
Male	10,055.0	6,238.9	620.5	3,750.5	601.15	373.00
Female	15,126.8	10,141.5	670.4	4,938.0	486.91	326.44
Race[2]						
White	22,297.7	14,644.1	656.8	7,806.9	533.11	350.12
All other	2,172.0	1,278.6	588.7	654.9	512.17	301.52
Census region						
Northeast	5,961.4	4,085.9	885.4	2,221.2	543.62	372.60
North Central	6,633.5	4,153.7	626.2	2,014.2	484.91	303.64
South	8,132.2	5,168.2	635.5	2,630.5	508.97	323.47
West	4,213.6	2,887.4	685.3	1,791.9	620.58	425.27

[1] As of July 1, 1981.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.17

Use of physicians' and other medical services by disabled Medicare enrollees, by demographic characteristics: Calendar year 1981

Characteristic	Disabled supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	2,759.5	1,717.5	622.4	$1,198.9	$698.08	$434.46
Age						
Under 35 years	352.7	177.8	504.2	135.0	758.99	382.76
35-44 years	352.3	194.1	550.9	138.1	711.77	392.00
45-54 years	596.3	361.0	605.4	258.2	715.18	433.00
55-59 years	594.0	375.5	632.2	261.6	696.64	440.40
60-64 years	864.3	609.0	704.7	406.0	666.69	469.74
Sex						
Male	1,723.9	978.2	567.4	673.6	688.62	390.74
Female	1,035.6	739.3	713.9	525.3	710.60	507.24
Race[2]						
White	2,242.3	1,408.3	628.1	976.0	693.03	435.27
All other	463.5	271.0	584.8	197.7	729.23	426.54
Census region						
Northeast	594.0	389.9	656.3	275.1	705.44	463.13
North Central	628.5	391.3	622.5	261.8	669.18	416.55
South	1,033.0	607.5	588.1	402.4	662.38	389.55
West	452.8	312.4	689.9	252.4	807.90	557.42

[1] As of July 1, 1981.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Reimbursement per person served was higher for aged white persons than for aged persons other than white. The opposite was true among disabled persons served.

Data by region show that aged and disabled enrollees living in the West had the highest amount reimbursed per person served. Aged enrollees living in the North Central region had the lowest rates of both persons served per 1,000 enrollees and amount reimbursed per person served.

Total charges of physicians, reasonable charges as determined by carriers, and amounts reimbursed by Medicare are shown in Table 3.18 for 1981. For both aged and disabled enrollees combined, the reduction in reasonable charges was 25 percent and varied little by region. The percent reduction was highest in the Northeast and lowest in the West. After carriers made reasonable charge reductions and subtracted deductible and coinsurance amounts, the percent of total physicians' charges reimbursed by Medicare was 57.2 percent. The proportion differed only slightly by region.

Figure 3.1 shows the distribution of total physicians' charges due (total charges less the reduction amount on unassigned claims) between the amount paid by Medicare and the amount of beneficiary liability. In 1981, among aged persons served, Medicare reimbursed 65.6 percent of total physicians' charges due. The remainder, 34.4 percent, comprised: coinsurance, 15.6 percent; reduction on unassigned claims, 13.5 percent; and deductible, 5.3 percent. The proportion reimbursed for disabled persons served, 69.6 percent, was somewhat higher than that of the aged.

Data on outpatient services provided to aged and disabled enrollees in 1981 are presented in Tables 3.19 and 3.20. Aged enrollees received $1,557 million in reimbursements; disabled enrollees received $791 million. The disabled accounted for 34 percent of total reimbursements for outpatient services, though they represented 10 percent of all enrollees. The number of persons served per 1,000 enrollees was higher for disabled than for aged enrollees. Reimbursement per person served was 3.7 times greater for the disabled ($811) than for the aged ($219). The highest average amount reimbursed per person served was $1,272 for disabled enrollees under 35 years of age, reflecting the relatively high proportion of disabled persons with end-stage renal disease in this age group.

Among aged enrollees, the number of persons served per 1,000 enrollees using outpatient services differed only slightly by sex and race. Differences by sex in reimbursements per person served were also small. However, the amount reimbursed per person served was 51 percent greater for persons of all other races than for whites.

Among disabled enrollees, the proportion of females who received benefits was almost 30 percent greater than the rate for males. Reimbursement per person served was also higher for females than for males, but by only 13 percent. By race, there was a striking difference in reimbursements per person served—$1,369 for all other races and $676 for whites. Races other than white also had a higher rate of persons served per 1,000 enrollees. As a result, 32 percent of all reimbursements for outpatient services received by disabled enrollees were for other races, although they comprised only 17 percent of all disabled enrollees.

Data for 1981 on covered hospital outpatient charges and reimbursements for aged and disabled enrollees (including the disabled with ESRD) are shown by census region in Table 3.21. The percent of charges reimbursed were 69.4 percent for aged enrollees and 73.8 percent for disabled enrollees. The amount reimbursed per enrollee was 238 percent greater for the disabled, primarily because of the inclusion of data on ESRD patients. Reimbursements per enrollee were lowest in the South for both aged and disabled enrollees. They were highest in the West for the aged and in the Northeast for the disabled. The percent of charges reimbursed was highest in the West and lowest in the Northeast.

Financing

HI is financed primarily through a tax on a portion of current earnings in employment covered under the Social Security Act. Other sources of income for the program (shown in Table 3.22) include proceeds from the railroad retirement system, income to the trust fund appropriated from general revenues to reimburse the program for costs of uninsured enrollees, and interest earned by the fund. These monies are earmarked for the HI trust fund to pay benefits and administrative expenses.

In 1981, payroll taxes accounted for 92 percent of the HI trust fund's total income. The share of total income from payroll taxes has remained at about this level for

Table 3.18

Physicians' charges and Medicare reimbursements, by census region: Calendar year 1981

Census region	Charges		Percent reduction in total charges	Reimbursements	
	Total	Reasonable		Amount in millions	As percent of total charges
	Amount in millions				
United States[1]	$16,713	$12,602	24.6	$9,565	57.2
Northeast	4,080	3,032	25.7	2,297	56.3
North Central	3,709	2,808	24.3	2,124	57.3
South	5,368	4,051	24.5	3,080	57.4
West	3,539	2,699	23.7	2,056	58.1

[1] Includes unknown residence.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Unpublished data.

Figure 3.1

Percent distribution of physicians' charges due for Medicare aged and disabled persons reimbursed: Calendar year 1981

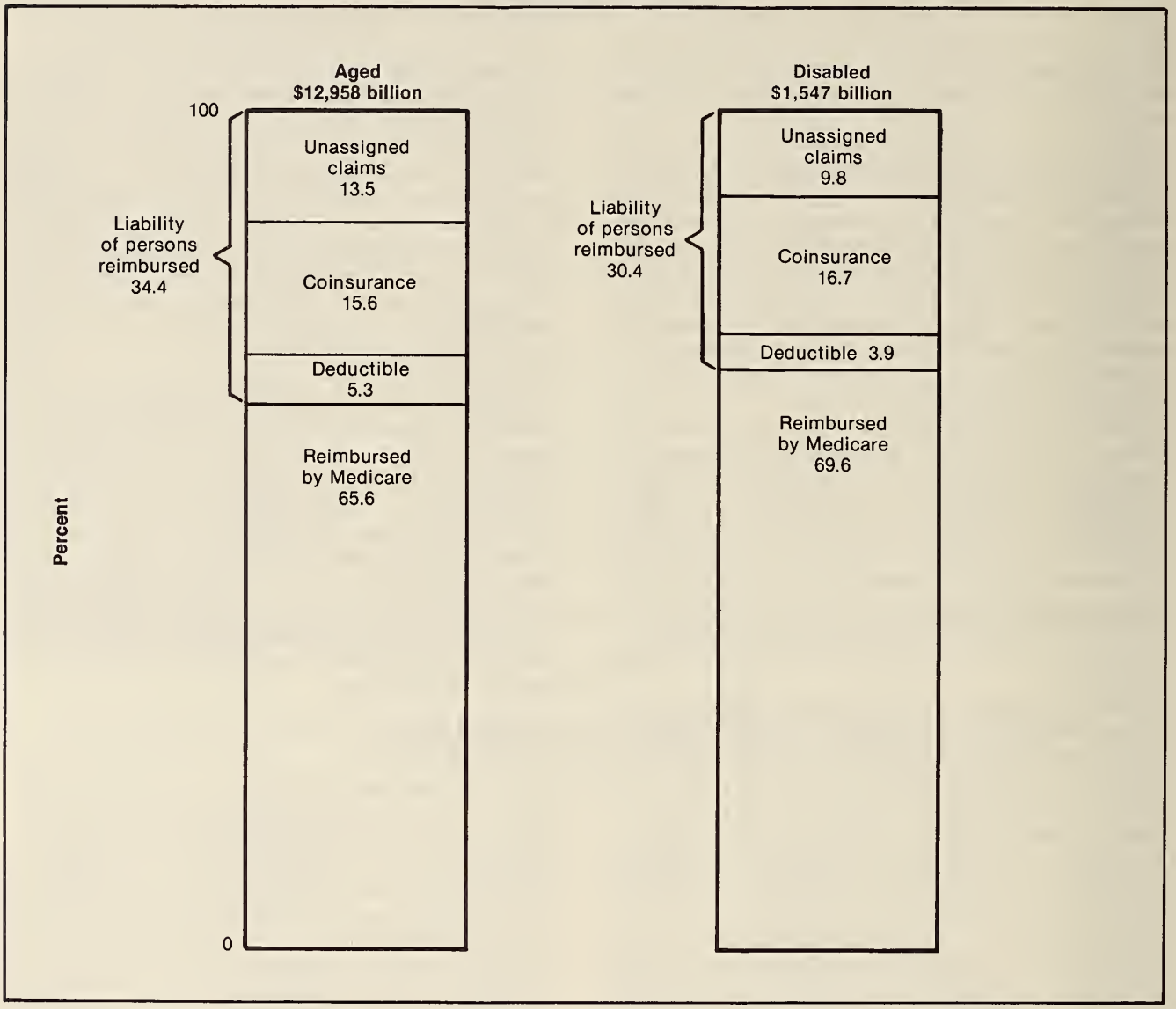


Table 3.19

Use of outpatient services by aged Medicare enrollees, by age, sex, and race: Calendar year 1981

Age, sex, and race	Aged supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in millions	Per person served	Per enrollee
Total	25,181.7	7,095.6	281.8	$1,556.6	$219.37	$61.82
Age						
65-69 years	8,270.3	2,154.9	260.6	488.0	226.44	59.01
70-74 years	6,706.4	1,854.6	276.5	436.8	235.51	65.13
75-79 years	4,809.4	1,401.7	291.5	314.9	224.62	65.48
80-84 years	3,015.1	919.7	305.0	180.7	196.47	59.93
85 years or over	2,380.6	764.7	321.2	136.3	178.21	57.25
Sex						
Male	10,055.0	2,748.4	273.3	651.7	237.11	64.81
Female	15,126.8	4,347.2	287.4	904.9	208.15	59.82
Race[2]						
White	22,297.7	6,239.7	279.8	1,304.6	209.08	58.51
All other	2,172.0	660.6	304.2	209.1	316.58	96.27

[1] As of July 1, 1981.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.20

Use of outpatient services by disabled Medicare enrollees, by age, sex, and race: Calendar year 1981

Age, sex, and race	Disabled supplementary medical insurance enrollees in thousands[1]	Persons served		Reimbursements		
		Number in thousands	Per 1,000 enrollees	Amount in in millions	Per person served	Per enrollee
Total	2,759.5	975.1	353.4	$791.3	$811.48	$286.76
Age						
Under 35 years	352.7	121.1	343.3	154.0	1,271.89	436.63
35-44 years	352.3	123.7	351.2	124.6	1,007.41	353.68
45-54 years	596.3	213.7	358.3	185.0	865.87	310.25
55-59 years	594.0	207.0	348.5	140.6	679.56	236.70
60-64 years	864.3	309.7	358.3	187.0	603.84	216.36
Sex						
Male	1,723.9	551.8	320.1	423.6	767.61	245.72
Female	1,035.6	423.3	408.8	367.7	868.67	355.06
Race[2]						
White	2,242.3	771.6	344.1	521.5	675.86	232.57
All other	463.5	183.3	395.5	250.9	1,368.76	541.32

[1] As of July 1, 1981.
[2] Excludes unknown race.

SOURCE: Health Care Financing Administration: *Annual Medicare Program Statistics, 1981.* HCFA Pub. No. 03153. Office of Statistics and Data Management. Washington. U. S. Government Printing Office, Aug. 1983.

Table 3.21

Hospital outpatient charges and Medicare reimbursements, by type of enrollee and census region: Calendar year 1981

Census region	Covered charges in millions		Reimbursements					
			Amount in millions		Per enrollee		As percent of of covered charges	
	Aged	Disabled[1]	Aged	Disabled[1]	Aged	Disabled[1]	Aged	Disabled[1]
All areas	$1,874.5	$651.9	$1,300.1	$481.2	$51.63	$174.37	69.4	73.8
United States	1,869.2	648.8	1,296.8	479.0	51.96	176.66	69.4	73.8
Northeast	564.9	183.5	374.3	130.5	62.79	219.64	66.3	71.1
North Central	499.2	181.4	346.4	136.4	52.21	217.01	69.4	75.2
South	417.7	152.6	289.8	111.8	35.63	108.20	69.4	73.3
West	387.3	124.5	286.3	95.0	67.96	209.84	73.9	76.3

[1] Includes enrollees with end-stage renal disease.

SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Medicare Use of Hospital Outpatient Services by the Aged and Disabled, 1981, unpublished data.

the last several years. In the 1960's, the payroll tax share fluctuated from a high of 95.6 percent in 1966 to a low of 77.9 percent in 1968. Since 1968, benefit payments have accounted for over 97 percent of all HI disbursements.

The Federal SMI trust funds (Table 3.23) come from premiums paid by or on behalf of SMI enrollees, contributions of the Federal Government from the general fund of the Treasury, and interest from investments of the fund. At the start of Medicare, the monthly SMI premium was $3.00. By January 1, 1984, the premium had risen to $14.60 per month. Until 1973, premiums were set to finance one-half of the benefit and administrative costs of the SMI program plus a contingency amount. General revenues financed the other half. The 1972 amendments altered that arrangement. Beginning July 1973, monthly premiums can be raised only if monthly social security cash benefits are increased. Furthermore, premiums are permitted to rise no more than the percentage increase in cash benefits. The Social Security Amendments of 1983 changed the premium adjustment period from a 12-month period ending in June 1983 to one ending in December 1983. Premium adjustments are now made for a calendar year. The Part B premium for January 1984 through December 1985 is set at 25 percent of the expected average cost for aged enrollees. New premium amounts will be set in September prior to the calendar year in which the premiums become effective. The determination of the premium rate for 1986 will revert to the provisions of the 1972 amendments. General revenues finance the benefit and administrative costs not covered through premiums.

Since the 1972 Social Security Amendments, the major source of income for the SMI trust fund has been Government contributions, which made up 73 percent of total income in 1981. Enrollees' premiums were 24 percent, and the remainder was interest on investments.

Administration

HI intermediaries

Under HI, groups or associations of providers may nominate a national, State, or other public or private agency or organization to be their intermediary. Under an agreement with the Secretary of DHHS, the intermediary determines reasonable costs for covered items and services, makes payment, and guards against unnecessary use of covered services. Some agreements also provide that the intermediary furnish consultative services to assist providers in establishing and maintaining the fiscal records needed to qualify as providers of service; serve as a center for communicating with providers; or audit provider records. In addition, HI intermediaries make payments for home health and outpatient hospital services covered by SMI.

Reasonable costs of services are determined by regulations of the Secretary of DHHS. Charges for covered services are generally submitted by the provider. The intermediary reimburses the provider for reasonable costs of covered services, less the deductible and coinsurance amounts. The beneficiary pays these amounts and pays for services not covered.

The intermediary reviews claims for payment and pays claims on the basis of interim rates established between the provider and the intermediary. Final settlement for each provider's operating year is based on a cost report of the provider and is subject to an independent audit.

Table 3.24 summarizes workload and cost data for HI intermediaries for 1975 through 1981. Although the number of bills processed increased 65.0 percent in that period, administrative costs increased by only 50.4 percent.

SMI carriers

The Secretary of DHHS contracts with carriers to perform certain administrative duties under SMI. Carriers compute reasonable charges and make payments. They also determine whether claims are for covered services, deny claims for noncovered services, and deny claims for unnecessary use of services. Workload and cost data for SMI carriers are presented in Table 3.25.

Claims for SMI benefits may be submitted to the carrier by patients or providers. If patients submit claims (itemized bills) directly to the carrier, they receive direct payment for covered services but remain responsible for the physician's (or supplier's) bill.

A physician or supplier of services may accept assignment, accepting the reasonable charge as determined by the carrier as the total charge. The physician (or supplier) submits the bill, and the carrier reimburses 80 percent of the reasonable charge. The patient is then responsible for the remaining 20 percent of the allowed charge and for the deductible, if applicable.

Table 3.22

Operations of the Medicare hospital insurance trust fund: Calendar years 1966-81

Year	Income								Disbursements			Trust fund	
	Total income	Payroll taxes	Transfers from railroad retirement account	Reimbursement for uninsured persons	Premiums from voluntary enrollees	Reimbursement for military wage credits	Reimbursement for PSRO[1] review	Interest on investment	Total disbursements	Benefit payments	Administrative expenses	Net change in fund	Fund at end of year
	Amount in millions												
1966	$1,943	$1,858	$16	$26	NA	$11	NA	$32	$999	$891	$108	$+944	$944
1967	3,559	3,152	44	301	NA	11	NA	51	3,430	3,353	77	+129	1,073
1968	5,287	4,116	54	1,022	NA	22	NA	74	4,277	4,179	99	+1,010	2,083
1969	5,279	4,473	64	617	NA	11	NA	113	4,857	4,739	118	+422	2,505
1970	5,979	4,881	66	863	NA	11	NA	158	5,281	5,124	157	+698	3,202
1971	5,732	4,921	66	503	NA	48	NA	193	5,900	5,751	150	−168	3,034
1972	6,403	5,731	63	381	NA	48	NA	180	6,503	6,318	185	−99	2,935
1973	10,821	9,944	99	451	$2	48	NA	278	7,289	7,057	232	+3,532	6,467
1974	12,024	10,844	132	471	5	48	NA	523	9,372	9,099	272	+2,652	9,119
1975	12,980	11,502	138	621	7	48	NA	664	11,581	11,315	266	+1,399	10,517
1976	13,766	12,727	143	[2]0	9	141	NA	746	13,679	13,340	339	+88	10,605
1977	15,856	14,114	[3]0	[2]803	12	[4]143	NA	784	16,019	15,737	283	−163	10,442
1978	19,213	17,324	214	688	13	141	$29	834	18,178	17,682	496	+1,035	11,477
1979	22,825	20,768	191	734	16	141	33	975	21,073	20,623	450	+1,751	13,228
1980	26,097	23,848	244	697	18	141	33	1,149	25,577	25,064	512	+521	13,749
1981	35,725	32,959	276	659	22	207	34	1,603	30,726	30,342	384	+4,999	18,748

[1] Professional standards review organization.

[2] No transfer was made in 1976 because of a change in transfer dates from December to March. The 1977 transfer was for benefits and administrative expenses during the 15-month period beginning July 1976 and ending September 1977.

[3] No transfer was made in 1977 because of a change in transfer dates from August to June. The 1978 transfer was for contributions during the 5-quarter period covering the transition quarter and fiscal year 1977.

[4] Includes $2 million reimbursement from general revenues for costs arising from the granting of noncontributory wage credits to persons of Japanese ancestry who were interned during World War II.

SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund: *1982 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*. Washington. U. S. Government Printing Office, Apr. 5, 1982.

Table 3.23

Operations of the Medicare supplementary medical insurance trust fund: Calendar years 1966-81

Year	Income				Disbursements			Trust fund	
	Total income	Premiums from enrollees	Government contributions[1]	Interest on investment	Total disbursements	Benefit payments	Administrative expenses	Net change in fund	Fund at end of year
	Amount in millions								
1966	$324	$322	$0	$2	$203	$128	$75	$+122	$122
1967	1,597	640	933	24	1,307	1,197	110	+290	412
1968	1,711	832	858	21	1,702	1,518	184	+9	421
1969	1,839	914	907	18	2,061	1,865	196	−222	199
1970	2,201	1,096	1,093	12	2,212	1,975	237	−11	188
1971	2,639	1,302	1,313	24	2,377	2,117	260	+262	450
1972	2,808	1,382	1,389	37	2,614	2,325	289	+193	643
1973	3,312	1,550	1,705	57	2,844	2,526	318	+468	1,111
1974	4,124	1,804	2,225	95	3,728	3,318	410	+395	1,506
1975	4,673	1,918	2,648	107	4,735	4,273	462	−62	1,444
1976	5,977	2,060	3,810	107	5,622	5,080	542	+355	1,799
1977	7,805	2,247	5,386	172	6,505	6,038	467	+1,300	3,099
1978	9,056	2,470	6,287	299	7,755	7,252	503	+1,301	4,400
1979	9,768	2,719	6,645	404	9,265	8,708	557	+502	4,902
1980	10,874	3,011	7,455	408	11,245	10,635	610	−372	4,530
1981	15,374	3,722	11,291	361	14,028	13,113	915	+1,347	5,877

[1] Payments from the general fund of the U. S. Treasury include certain interest-adjustment items.

SOURCE: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund: *1982 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.* Washington. U. S. Government Printing Office, Apr. 5, 1982.

Table 3.24

Medicare hospital insurance intermediaries; workload and cost data: Fiscal years 1975-81

Year	Bills processed		Total administrative cost		Total unit cost		Revised administrative cost		Unit cost excluding audit		Provider audit and reimbursement cost	
	Number in thousands	Index	Amount in millions	Index	Amount	Index	Amount in millions[1]	Index	Amount	Index	Amount in millions	Index
1975	25,723.4	100.0	$151.8	100.0	$5.90	100.0	$121.5	100.0	$4.72	100.0	$36.8	100.0
1976	25,898.7	112.3	164.8	108.6	5.70	96.6	133.0	109.4	4.60	97.5	39.7	107.8
1977	32,119.0	124.1	182.3	120.1	5.68	96.3	146.8	120.8	4.57	96.8	44.1	120.0
1978	34,862.4	135.5	191.3	126.0	5.49	93.1	141.8	116.7	4.07	86.2	47.7	129.6
1979	36,410.1	141.5	201.5	132.8	5.54	93.9	147.4	121.3	4.05	85.8	52.0	141.3
1980	41,846.7	162.7	223.9	147.5	5.35	90.7	157.8	129.9	3.77	79.9	64.0	173.9
1981	42,444.1	165.0	228.3	150.4	5.38	91.2	159.7	131.4	3.76	79.7	67.2	182.6

[1] For fiscal year (FY) 1975, excludes provider audit cost. For FY 1976 and 1977, excludes provider audit, professional standards review organization (PSRO), and health maintenance organization (HMO) costs. For FY 1978-81, excludes provider reimbursement, provider audit, PSRO, and HMO costs.

SOURCE: Health Care Financing Administration: *Medicare Annual Report, Fiscal Year 1981.* HCFA Pub. No. 02156, 1984.

Table 3.25

Medicare supplementary medical insurance carriers; workload and cost data: Fiscal years 1975-81

Year	Claims processed		Total administrative cost		Claims unit cost		Payment records processed		Payment records unit cost	
	Number in thousands	Index	Amount in millions	Index	Amount	Index	Number in thousands	Index	Amount	Index
1975	80,613.7	100.0	$258.7	100.0	$3.21	100.0	63,837.4	100.0	$4.05	100.0
1976	92,399.5	114.6	290.2	112.2	3.14	97.8	75,266.1	117.9	3.86	95.3
1977	108,126.3	134.1	322.6	124.7	2.98	92.8	88,983.8	139.4	3.63	89.6
1978	120,439.7	149.4	344.6	133.2	2.86	89.1	100,087.3	156.8	3.43	84.7
1979	133,494.9	165.6	375.3	145.0	2.81	87.5	112,864.6	176.8	3.32	82.0
1980	143,121.5	177.5	384.7	148.7	2.69	83.8	121,868.3	190.9	3.16	78.0
1981	159,785.9	198.2	428.9	165.8	2.68	83.5	138,684.9	217.2	3.09	76.3

SOURCE: Health Care Financing Administration: *Medicare Annual Report, Fiscal 1981.* HCFA Pub. No. 02156, 1984.

Prepaid health plans

Group practice prepayment plans (GPPP's)[7] and health maintenance organizations (HMO's) are prepaid health plans that render physicians' and other health care services to voluntarily enrolled subscribers in return for predetermined premium payments. This differs from the more common method of payment on a per visit or per service basis.

Prepaid health plans that provide services to Medicare enrollees have several options for participation in Medicare. They may contract to deal directly with Medicare either under Section 1833 as group practice prepayment plans or under Section 1876 as health maintenance organizations. HMO's may contract on a cost-reimbursement basis or on a risk basis. Plans that do not contract directly with Medicare, "carrier dealing" plans, bill and receive reimbursement through the regular Medicare fee-for-service billing procedures. In all cases, Medicare beneficiaries pay the plan (or have paid on their behalf through employment or retirement benefits) a supplementary premium to cover the Medicare deductible, coinsurance, and any benefits or services provided by the plan but not covered by Medicare.

The number of contracting GPPP's and HMO's and their Medicare members are shown by size of Medicare membership in Table 3.26. As of March 1983, the 106 contracting prepaid health plans had a total of 696,296 Medicare members, about 2 percent of the total Medicare population. The four largest plans, all GPPP's, accounted for 59 percent of all Medicare members of prepaid health plans.

Group practice prepayment plans

Section 1833 was written into the original Medicare legislation to enable GPPP's to participate in Medicare with minimal constraints. GPPP's are paid monthly interim payments for Part B physicians' and related services based on estimated allowed costs per Medicare beneficiary and the number of Medicare member-months covered. At the end of the fiscal year, a post-audit adjustment is made based on the portion of audited physician and related costs allocated to Medicare members. Other Medicare-covered services provided by the plan are billed on the basis of charges related to cost through the routine Medicare billing procedures (that is, through carriers and intermediaries). These services may include HI hospital, skilled nursing facility, and home health agency services.

A wide variety of plans are currently under Section 1833 contracts, including some of the oldest and largest plans in the country. In comprehensiveness of service, GPPP's vary from little more than ambulatory primary care to a full range of services, including dental and eye care, inpatient hospital and SNF care, and home health services. Several GPPP's own or operate their own hospitals, SNF's, and HHA's. Medicare members of GPPP's may also use out-of-plan services and receive Medicare reimbursement for them. This provision allows Medicare members of GPPP's that do not provide comprehensive Medicare-covered services to receive full Medicare benefits. Reimbursement for out-of-plan services is through the routine Medicare billing process.

Health maintenance organizations

The favorable cost experience of a few GPPP's led to the Federal policy of encouraging this form of health care delivery and payment for Medicare beneficiaries. In 1972, Section 1876 was added to the Medicare law to specify how and under what conditions HMO's may contract with Medicare. To encourage HMO's to enroll Medicare beneficiaries, the law gives them the opportunity to share in cost savings resulting from efficient management and use of resources by entering into risk-basis contracts. If they do not choose this option or cannot meet the specifications for risk contracting, they may enter into cost-basis contracts.

[7] Medicare regulations in 1983 changed the name from GPPP's to health care prepayment plans.

Table 3.26

Number of group practice prepayment plans and health maintenance organizations participating in Medicare and number of Medicare members, by size of Medicare membership: March 1983

Size of Medicare membership	Total		GPPP's[1]		HMO's[2]	
	Plans	Medicare members	Plans	Medicare members	Plans	Medicare members
	Number					
All sizes	[3]106	696,296	36	539,609	70	156,687
Less than 100	10	253	1	20	9	233
100-499	21	6,353	5	1,219	16	5,134
500-999	18	13,549	3	2,202	15	11,347
1,000-4,999	37	82,268	15	35,739	22	46,529
5,000-9,999	9	66,266	4	34,238	5	32,028
10,000-19,999	6	87,284	4	52,702	2	34,582
20,000-49,999	1	26,834	0	0	1	26,834
50,000-99,999	1	82,102	1	82,102	0	0
100,000 or more	3	331,387	3	331,387	0	0

[1] Group practice prepayment plans.
[2] Health maintenance organizations.
[3] The Portland Kaiser Plan is counted twice because it has an HMO demonstration contract for 7,527 Medicare members and a GPPP contract for 15,421 Medicare members.

SOURCE: Health Care Financing Administration, Group Health Plans Operations Staff: Unpublished data.

Two major requirements of a contracting HMO are: certification as federally qualified by the Office of Health Maintenance Organizations of the Public Health Service and availability to its Medicare enrollees, either directly or under contractual arrangements with area providers, of all Medicare-covered services normally available to fee-for-service Medicare beneficiaries in its service area. (Developing HMO's are given 3 years to meet the latter requirement.) Thus, requirements for HMO's are considerably more stringent and restrictive than those for GPPP's. A plan that operates as an HMO for its general membership but has not contracted with HCFA to serve Medicare enrollees as an HMO is classified as a GPPP in Table 3.26. As of March 1983, 70 HMO's with a total of nearly 157,000 Medicare members were under Section 1876 contracts.

Cost-contracting HMO's function very much like GPPP's as regards the Medicare program. They receive monthly interim payments during the year based on their estimated allowed costs (with a postaudit adjustment to actual allowed costs at the close of the year), and their Medicare members may use and receive Medicare reimbursement for out-of-plan services. A major difference is that HMO payments may include all HI and SMI services, whereas GPPP payments are limited to SMI physician and related medical services only, even if the GPPP provides other Medicare-covered services to its Medicare members.

Section 1876 risk-contracting HMO's also receive interim payments during the year. However, in its postaudit adjustment each HMO's savings or losses are determined by comparing its audited allowed costs per Medicare member with the "adjusted average per capita cost" (AAPCC) for its service area. The AAPCC is computed by applying a geographic index, specific to the HMO's service area, to the average per capita costs for all Medicare beneficiaries, then further adjusting for characteristics of the HMO's Medicare membership, such as age, sex, institutionalized status, and public assistance status. Separate HI and SMI AAPCC's are calculated for Medicare aged and disabled beneficiaries. If the HMO's costs are higher than its AAPCC, it must absorb the loss or carry it over to be offset by future savings. If its costs are less than the AAPCC, it shares the "savings" with the Medicare program. HMO's may reserve savings of up to 10 percent of the AAPCC.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) authorized prospective reimbursement under risk contracts with HMO's and other eligible organizations at a rate equal to 95 percent of the AAPCC. This provision took effect in January 1985. The number of HMO's contracting with Medicare is expected to increase significantly.

A major difference between risk-contracting HMO's and other contracting plans is that Medicare members of such HMO's are "locked in" to the plans' services; that is, they cannot choose to use out-of-plan services and receive Medicare reimbursement for them. (Exceptions are emergency service and "urgently needed" out-of-area services.) Thus, risk-contracting HMO's must make all Medicare-covered services available to Medicare members.

Medicare statistical system

The Medicare statistical system provides data for analyzing and evaluating the program's effectiveness. It consists of four major computer files: the health insurance master file, the provider of service file, the HI claims file, and the SMI payment records file.

The health insurance master file contains records for aged and disabled enrollees, including information on each enrollee's type of entitlement, deductible status, benefit period status, and benefits used. This file provides population data for the program and is the base used in computing a variety of user rates by age, sex, race, and residence.

In the provider of service file, information is maintained on hospitals, home health agencies, skilled nursing facilities, independent clinical laboratories, and suppliers of portable X-ray or outpatient physical therapy services who participate in Medicare. The provider of service file consists of data from the provider application-for-participation forms. For hospitals, it includes data on the number of beds, type of ownership, and other characteristics. Provider data are updated regularly.

In the HI claims file, information is maintained on beneficiaries' entitlement and the extent to which enrollees have used covered benefits. When an enrollee uses a participating medical facility (for example, a hospital or skilled nursing facility), admission and billing forms are forwarded to HCFA's central office. This office records all "benefit period" information needed by carriers. Information on stays in certain nonparticipating institutions and days of care not covered or reimbursable under the program is included. The admission and billing form contains both a Medicare enrollee identification number and a provider number. A computer tape record of this form, when matched with enrollee entitlement and provider tapes, forms a statistical research tape. The resulting tape provides enrollee, provider, use of service, and cost data for each enrollee. Information on diagnoses and surgical procedures is obtained for a 20-percent sample of hospitalized enrollees.

The HCFA central SMI payment records file is used to inform carriers whether or not enrollees have met the deductible. It also provides information on amounts paid by carriers for physicians' services and other SMI-covered services and supplies. A bill summary file is derived from a sample of the SMI payment records file for statistical research.

To better meet Medicare's data needs on physician reimbursements, the following four files will be generated from all SMI carrier service data:

- A procedure file containing complete counts of all physician medical procedures, amounts charged, and amounts paid. This will, for the first time, provide complete information on Medicare physician and supplier services.
- A prevailing charge file will provide information on the prevailing charge for each service in the procedure file. This will allow HCFA to study and forecast payment levels more accurately.

- A provider file will contain data from submitted claims for all services rendered by a sample of physicians and other suppliers. This will allow study of the effect of program changes on physicians' service practices and permit longitudinal analysis of these practices.
- A beneficiary file will provide a complete record, from submitted claims, of services received by a sample of beneficiaries. This will permit linkage of information on beneficiaries' use of physicians' and other suppliers' services to already existing files containing data on the use of HI services.

These four files will supplement data currently available. They will be used by numerous bureaus and offices in HCFA. For the Office of Research and Demonstrations, for example, these files will be useful for providing data and analysis on the levels of specific procedures, physician practices, and patient episodes.

The Medicare statistical system enables HCFA to prepare a wide variety of research studies on the use and reimbursement of Medicare services. These data provide information about the use of benefits by enrollees for a point in time or over an extended period. Statistical reports are produced on enrollment, characteristics of participating providers, reimbursements, and services used.

Medicare has also implemented the Continuous Medicare History Sample (CMHS) beginning with the 1974 data. CMHS provides longitudinal data on Medicare program use by a sample of enrollees. The CMHS file consists of data from all Medicare user files for a number of years. Selected data from the enrollment and user files have been combined into one record for each sample person to acquire specific person data.

CMHS is a 5-percent probability sample of Medicare health insurance claim numbers. New enrollees whose claim numbers place them in CMHS are added to the sample, and records for enrollees whose Medicare coverage ends are retained in the file. The ability to link different data files over a period of years is a key feature of CHMS and the Medicare statistical system. It permits detailed analysis of specific groups of enrollees over time.

4. Medicaid: Description and data

Detailed information on the Medicaid program, including eligibility criteria, recipient characteristics, benefit coverage, service use, expenditures, financing, and administration, are presented in this chapter.[8] Explanations of program requirements are based on regulations contained in Title 42 of the U.S. Code of Federal Regulations (CFR), Parts 430-456.

First, information is given on Federal requirements and State options in defining the eligibility of the categorically and medically needy. Data are presented on the distribution of recipients by State, eligibility category, age, and sex. Medicaid benefits offered by each State, including optional services, benefit limitations, and cost-sharing requirements, are described. Data on the use of Medicaid-covered services are also presented. For each State, the data show the distribution of recipients by type of service used, the number of recipients, and the total volume of services by service type.

The next focus is Medicaid expenditures. The distribution of State expenditures is shown by eligibility category, age, and sex of recipients and by type of service. Comparisons of average expenditures per recipient by State and ratios of Medicaid recipients to persons at or below the poverty level are also presented. Medicaid financing, including information on matching rates for Federal financial participation, is described next.

Various topics concerning Medicaid administration, including provider reimbursement methods, expenditures for administration and training, number of certified providers, administrative responsibility for eligibility determination, and adoption of management information systems, are discussed. Finally, the Medicaid data system is described.

Eligibility

Medicaid is a major component of the current public assistance system, and its eligibility provisions are among the most complex of all assistance programs. At a minimum, States must cover all persons who receive cash payments from the Aid to Families With Dependent Children (AFDC) program and most persons receiving assistance from the Supplemental Security Income (SSI) program. States have the option of extending Medicaid coverage to the medically needy and to specified groups of people known as the optionally categorically needy. The medically needy are defined as individuals in categories related to AFDC and SSI who are ineligible for cash assistance on the basis of income and financial resources but whose income and resources are considered insufficent to meet their medical needs. This section describes the standards States use to determine who is eligible for Medicaid.

The categorically needy

As shown in Figure 4.1, the categorically needy include AFDC and SSI cash assistance recipients and may also include optional groups related to each cash assistance category. The AFDC and SSI categories are discussed below.

Aid to Families With Dependent Children

The Federal Government offers States a number of options for Medicaid coverage through their AFDC programs. State Medicaid programs *must* cover all persons receiving cash assistance under the State's AFDC plan and families terminated from cash assistance because of increased earnings or hours of employment. Prior to the enactment of the Omnibus Budget Reconciliation Act of 1981 (OBRA-81), States also were required to provide Medicaid coverage to qualifying persons under age 21 who met age or school attendance requirements for AFDC. Section 2172 of OBRA-81 dropped this requirement, making coverage of such individuals a State option. States now may limit such coverage to children under 21, 20, 19, 18, or any other reasonable age. At State option, the AFDC State plan may include families with unemployed parents and children 18 years of age who are regularly attending school.

If the State extends AFDC coverage to these groups, it must extend Medicaid coverage as well.

Prior to October 1, 1981, each State had the option of extending AFDC eligibility to children 18-20 years of age who were regularly attending school or a course of vocational or technical training. OBRA-81 restricted this optional coverage to 18-year-olds who are full-time students in secondary school or the equivalent level of vocational or technical training and who can reasonably be expected to complete the program before reaching their 19th birthday. Before enactment of OBRA-81, States also had the option of extending Medicaid coverage to "unborn children" under their AFDC program. OBRA-81 effectively deleted Medicaid benefits for "unborn children" under the AFDC program and substituted coverage of pregnant women. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 subsequently revised Medicaid law to provide coverage directly to pregnant women and also extended direct coverage to "unborn children," previously provided on a temporary basis under 42 CFR 435.222.

At State discretion, a Medicaid program can extend benefits to certain other AFDC-related groups. The optional categorically needy groups are listed in the order in which they appear in Table 4.1. Prior to the enactment of OBRA-81, States could extend coverage to another optional categorically needy group known as "caretaker relatives." For further information, see 42 CFR Part 435.

- All persons under age 21 (or at State option, another specified age) who meet the AFDC income and resource limits but do not meet the definition of a dependent child under the AFDC program. States may limit coverage to certain groups, such as children in foster

[8] Data shown in tables may differ from those in previous publications, including those found in former editions of this data book. These differences are due mainly to late reports and adjustments received by HCFA.

Figure 4.1
Eligibility coverage of the categorically needy: October 1, 1982

Eligibility criteria for the categorically needy

- Aged, blind, disabled, or member of family unit deprived of support of parent
- Income standard
- Resource standard

AFDC populations for which coverage is:

Mandatory

- Individuals receiving AFDC payments (42 CFR 435.110)
- Families terminated from AFDC because of increased earnings or hours of employment (42 CFR 435.112)
- Individuals ineligible for AFDC because of requirements that do not apply under Title XIX of the Social Security Act (42 CFR 435.113)
- Individuals who would be eligible for AFDC except for increased OASDI income under Public Law 92-336 of July 1, 1972 (42 CFR 435.115)
- Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act (42 CFR 435.118)

Optional

- Individuals eligible for but not receiving cash assistance (42 CFR 435.210)
- Individuals who would be eligible for cash assistance except for institutional status (42 CFR 435.211)
- Individuals who would be eligible if child care costs were paid from earnings (42 CFR 435.220)
- Individuals under age 21 who should be eligible for AFDC but do not qualify as dependent children (42 CFR 435.222)
- Individuals who would be eligible if coverage under State's AFDC plan were as broad as allowed under Title IV-A of the Social Security Act (42 CFR 435.223)

SSI populations for which coverage is:

Mandatory

- Individuals receiving SSI payments (42 CFR 435.120)

  Individuals in States using more restrictive requirements for Medicaid than SSI (42 CFR 435.121)
- Individuals ineligible because of requirements that do not apply under Medicaid (42 CFR 435.122)
- Individuals receiving mandatory State supplements (42 CFR 435.130)
- Individuals who in Dec. 1973 were eligible for Medicaid as an essential spouse and who have continued to live with and be essential to the well-being of a recipient of cash assistance (42 CFR 435.131)
- Institutionalized individuals eligible in December 1973 (42 CFR 435.132)
- Blind and disabled individuals eligible in December 1973 (42 CFR 435.133)
- Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 of July 1, 1972 (42 CFR 435.134)
- Individuals who (a) become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977; (b) would still be eligible for SSI or SSP if that increase was deducted from income (42 CFR 435.135)

Optional

- Individuals eligible for but not receiving cash assistance (42 CFR 435.210)
- Individuals who would be eligible for cash assistance except for institutional status (42 CFR 435.211)
- Individuals who would be eligible for AFDC if child care costs were paid from earnings (42 CFR 435.220)
- Individuals receiving only optional State supplements (42 CFR 435.230)
- Individuals in institutions who are eligible under a special income level (42 CFR 435.231)
- Individuals receiving home- and community-based services who are eligible under a special income level (42 CFR 435.232)

NOTE: AFDC=Aid to Families with Dependent Children.
SSI=Supplemental Security Income.
OASDI=Old Age, Survivors, and Disability Insurance.
SSP=State Supplemental Payments.
CFR=Code of Federal Regulations.

homes, subsidized adoptions, psychiatric institutions, or intermediate care facilities (42 CFR 435.222).
- Individuals who are eligible for but are not receiving cash assistance (42 CFR 435.210).
- Individuals who would be eligible for AFDC cash assistance if they were not institutionalized (42 CFR 435.211).
- Persons who would be eligible for AFDC payments if the State AFDC program were as broad as Title IV-A of the Social Security Act allows (42 CFR 435.223).
- Individuals who would be eligible for AFDC payments if child care cost were paid from earnings (42 CFR 435.220).

Table 4.1

Medicaid coverage under Aid to Families With Dependent Children, by jurisdiction: March 1983

Medicaid jurisdiction	Included in AFDC[1] State plan			Optional categorically needy				
						Persons who would be eligible		
	Families with unemployed parents	Pregnant women with no eligible children	Children age 18 regularly attending school	Financially eligible persons under age 21	Persons eligible for but not receiving aid	Except for their institutional status	If state plan were as broad as Social Security Act allows	If child care costs were paid from earnings
Alabama				x		x		
Alaska		x		x	x	x		
Arkansas				x		x		
California	x	x	x	x	x	x		x
Colorado	x	x	x			x		x
Connecticut	x	x	x	x	x			
Delaware	x	x				x		
District of Columbia	x	x	x	x	x	x	x	x
Florida		x				x		
Georgia						x		
Hawaii	x	x	x		x	x		x
Idaho		x	x	x	x	x		
Illinois	x		x					
Indiana				x				
Iowa	x			x		x	x	
Kansas	x	x	x					
Kentucky			x				x	
Louisiana		x	x			x		
Maine			x					x
Maryland	x	x	x	x	x			
Massachusetts	x	x	x	x	x	x		
Michigan	x	x	x	x				
Minnesota	x	x	x	x	x	x	x	x
Mississippi						x		
Missouri	x		x				x	x
Montana		x	x	x	x	x		x
Nebraska	x	x	x			x		
Nevada		x	x	x				
New Hampshire					x	x		x
New Jersey	x		x	x	x	x		
New Mexico		x	x			x		
New York	x	x	x	x	x	x		x
North Carolina			x		x			
North Dakota		x	x	x		x		
Ohio	x	x	x			x		
Oklahoma			x	x	x	x		x
Oregon		x	x		x	x		
Pennsylvania	x		x	x	x	x		x
Rhode Island	x	x	x		x	x		x
South Carolina			x			x		
South Dakota						x		
Tennessee		x				x		
Texas			x	x		x		
Utah		x	x	x	x	x		x
Vermont	x		x	x	x	x		x
Virginia			x		x	x		
Washington	x	x	x		x	x		
West Virginia	x				x			
Wisconsin	x	x	x	[2]x	x	x	x	x
Wyoming		x	x			x		

[1] Aid to Families With Dependent Children.
[2] Persons age 19-24 not receiving Supplemental Security Income are not covered.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, and La Jolla Management Corporation: *Analysis of State Medicaid Program Characteristics.* Rockville, Md., 1983.

Income standards for cash assistance and Medicaid eligibility are set by the States. Table 4.2 presents the annual AFDC need and payment standards used by States to determine Medicaid eligibility for AFDC recipients, and for the medically needy in States with such a program, in 1983. (Eligibility standards for the medically needy are discussed later.) Data are shown for two-person and four-person families. Data for other family sizes are available from State public assistance plans.

The need standard is the amount of money a State determines essential to meet a minimum standard of living in that State for a specified family size. In general, the standard provides for basic consumption items, such as food, clothing, shelter, fuel and utilities, personal care items, household items, and in certain cases, special or recurrent needs. Some States vary the need standard to reflect differences in actual costs within the State, others vary it by season, and one varies it according to the age of the child.

In addition to the need standard, States also set the standard of payment for AFDC families. Payment standards vary widely, from a high of $9,012 in Alaska to a low of $1,692 in Texas for four-person families. (Table 4.2 does not include program data for the four territories of Guam, the Northern Marianas, Puerto Rico, and the Virgin Islands.) In most States, the payment standard is the maximum amount of cash assistance paid to a family with no countable income. Approximately one-half of the States set a payment standard that is lower than the need standard. It should be noted, however, that these States may provide a substantially higher level of assistance than a State meeting full need under a relatively low standard.

Supplemental Security Income

Prior to 1974, States had the same authority to set cash assistance and Medicaid eligibility standards for the aged, blind, and disabled as they had for the AFDC population. Since 1974, however, the Federal SSI program has included minimum income standards for cash assistance to the aged, blind, and disabled.

When the SSI program began, States were permitted to choose one of three ways to determine Medicaid eligibility for these persons. The Medicaid program could cover:

- All persons receiving an SSI benefit, including their eligible spouses,
- All persons receiving an SSI benefit or State supplementary payment, including their eligible spouses or
- All persons who met the eligibility criteria for medical assistance in effect on January 1, 1972, or some less restrictive criteria. These criteria must be no more liberal than the criteria for SSI benefits or State supplements, and they must be applied to the individual's income after subtracting his or her SSI benefit, State supplementary payment, and incurred medical expenses. States taking this option are known as "209(b)" States, and the deduction is referred to as the "209(b) spend-down."

States were also required to provide Medicaid coverage to the following groups which were eligible for Medicaid in December 1973.

- Individuals receiving a mandatory State supplementary payment (42 CFR 435.130).
- Essential spouses (42 CFR 435.131).
- Institutionalized individuals (42 CFR 435.132).
- Blind or disabled individuals (42 FR 435.133).

Coverage of these groups was required to prevent loss of eligibility for cash assistance recipients in the transition to SSI. Individuals could have lost eligibility if States narrowed their definitions of disability or visual impairment. To prevent this, on December 1973, recipients of Aid to the Blind and Aid to the Permanently and Totally Disabled were deemed to meet the SSI criteria for blindness or disability in States with more liberal categorical definitions. Individuals also could have lost their eligibility if SSI used lower income and resource levels than their State had previously employed. Therefore, States with more liberal financial standards were required to pay the difference between the lower SSI benefit and the individual's previous cash benefit and to extend Medicaid benefits to such individuals. This requirement is called mandatory supplementation. Although the mandatory supplement comes out of State revenues, it may be administered by the Federal Government at State option.

To protect individuals in States choosing not to extend Medicaid coverage to all SSI recipients, the law required that all 209(b) States adopt a "spend-down" for Medicaid. In determining eligibility for Medicaid assistance, 209(b) States must exclude from the applicant's income, the SSI payment, any optional State supplement an individual receives, and any medical expenses incurred by the applicant. This 209(b), or categorically needy, spend-down applies only to those categories for which states impose more restrictive eligibility criteria. (The State may elect not to impose more restrictive criteria on all categories.) Although the provisions are directed primarily at States choosing to impose more restrictive income standards, they are applicable to any State criteria that are more restrictive than those used under SSI. As a result of these provisions, even 209(b) States without a medically needy program must permit all individuals to spend down; however, non-209(b) States need not extend this coverage.

The option to cover certain additional groups as categorically needy was also offered to the States. These groups could be covered no matter which of the following three basic coverage options the State chose: (1) persons eligible for but not receiving cash assistance (42 CFR 435.210); (2) certain institutionalized persons (42 CFR 435.211 and 231); (3) individuals receiving only optional State supplements (42 CFR 435.230). States electing to make optional supplementary payments are permitted to limit payments to reasonable classificiations of categorically related individuals. Table 4.3 shows the SSI-related groups eligible for Medicaid coverage in March 1983 by jurisdiction.

States have the option of covering two other groups. Section 2176 of OBRA, effective October 1, 1981, permits the Secretary of the Department of Health and Human Services (DHHS) to offer under a waiver an array of home and community-based services that an individual needs to avoid institutionalization. Regulations at 42 CFR 441, Subpart G, specify that home and community-

based services must be provided under a written plan of care to individuals who would otherwise require the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF). Services may include case management, homemaker or home health aide services, personal care services, adult day health, habilitative services, respite care, and other services as approved by the Secretary, such as transportation, Meals on Wheels, hospice care and counseling.

Table 4.2

Annual need and payment standards for Aid to Families With Dependent Children and annual income levels for the medically needy, by family size and jurisdiction: March 1983

Medicaid jurisdiction	AFDC[1] standard				Income level protected for maintenance for medically needy[2]		
	2-person family		4-person family				
	Need	Payment	Need	Payment	1-person family	2-person family	4-person family
Alabama	$3,456	$1,416	$5,760	$1,776	—	—	—
Alaska	7,164	7,164	9,012	9,012	—	—	—
Arkansas	2,316	1,392	3,276	1,968	$1,800	$1,896	$2,700
California	6,528	4,896	9,612	7,212	3,972	6,528	9,612
Colorado	3,684	3,024	5,640	4,644	—	—	—
Connecticut	4,296	4,296	6,204	6,204	3,996	5,400	7,200
Delaware	2,364	2,364	3,744	3,744	—	—	—
District of Columbia	5,544	2,841	8,580	4,394	3,600	3,768	5,844
Florida	3,564	2,064	5,616	3,156	—	—	—
Georgia	5,508	1,944	7,776	2,748	—	—	—
Hawaii	4,680	4,680	6,552	6,552	3,600	4,800	6,600
Idaho	5,352	2,940	6,648	3,648	—	—	—
Illinois	4,464	3,000	7,920	4,416	2,856	3,000	4,416
Indiana	2,964	2,664	4,356	3,924	—	—	—
Iowa	4,032	3,504	5,684	5,028	—	—	—
Kansas	3,360	3,360	4,620	4,620	3,720	4,680	4,920
Kentucky	1,944	1,944	2,820	2,820	2,196	2,604	3,804
Louisiana	4,355	1,656	7,440	2,808	2,004	2,304	3,804
Maine	4,188	3,036	7,116	5,160	3,600	4,092	6,900
Maryland	3,492	2,760	5,400	4,260	3,200	3,700	4,700
Massachusetts[3]	3,960	3,768	5,604	4,340	3,996	5,100	5,340
Michigan[4]	4,284	3,924	6,096	5,580	3,708	5,232	5,580
Minnesota	4,416	4,416	6,240	6,240	3,756	4,716	6,672
Mississippi[5]	2,928	2,928	3,924	3,924	—	—	—
Missouri	3,000	2,508	4,380	3,660	—	—	—
Montana	4,044	3,348	6,156	5,100	3,420	4,500	5,100
Nebraska	3,360	3,360	5,040	5,040	3,396	4,500	6,300
Nevada	2,748	2,196	4,092	3,264	—	—	—
New Hampshire	3,504	3,504	4,704	4,704	2,988	3,504	4,704
New Jersey	3,276	3,276	4,968	4,968	—	—	—
New Mexico	2,268	2,268	3,372	3,372	—	—	—
New York[4]	5,064	5,064	7,224	7,224	4,200	6,100	6,300
North Carolina	4,224	2,112	5,304	2,652	2,200	2,900	3,600
North Dakota	3,469	3,468	5,244	5,244	3,180	4,620	6,360
Ohio	4,716	2,592	7,008	3,924	—	—	—
Oklahoma	2,616	2,616	4,188	4,188	2,904	3,504	5,604
Oregon[6]	3,744	3,636	5,352	4,296	3,924	4,980	7,116
Pennsylvania	5,633	3,276	8,100	4,980	3,800	4,400	6,000
Rhode Island	4,440	4,440	6,240	6,240	4,596	5,100	7,200
South Carolina[5]	1,728	1,272	2,748	2,028	—	—	—
South Dakota	3,360	3,360	4,332	4,332	—	—	—
Tennessee	1,704	1,212	2,604	1,848	1,404	1,620	2,460
Texas	1,464	1,020	2,412	1,692	—	—	—
Utah	5,315	3,468	8,364	5,460	3,444	4,620	7,284
Vermont	5,292	3,444	8,064	5,244	3,984	6,168	6,828
Virginia	3,444	3,096	4,800	4,320	3,096	3,804	4,404
Washington	6,720	4,380	9,768	6,372	3,876	5,556	6,372
West Virginia	2,628	1,968	3,984	2,988	2,400	2,700	3,300
Wisconsin, Region I	6,156	5,232	8,640	7,344	4,608	6,900	8,472
Wisconsin, Region II	5,976	5,076	8,388	7,128	4,608	6,900	8,472
Wyoming	3,840	3,840	4,680	4,680	—	—	—

[1] Aid to Families With Dependent Children.
[2] The following 19 States do not include the "medically needy" in their Medicaid program: Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, South Carolina, South Dakota, Texas, and Wyoming.
[3] Includes quarterly grant monies.
[4] Michigan and New York have differentiated shelter cost areas. Wayne County, Michigan, shelter maximums are reported.
[5] Maximum annual payment amount is lower than the payment standard.
[6] Oregon standards effective January 1, 1984.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Unpublished data.

Waivers are granted for a 3-year period and may be renewed. By October 1, 1984, 47 States had submitted 135 waiver requests for home and community-based services. Of these, 78 requests from 45 States had been approved.

Section 134 of TEFRA, effective October 1, 1982, permits States to cover certain disabled children 18 years of age or under who live at home. These "model waivers," as they are called, are limited to 50 or fewer eligible individuals. Prior to the availability of section 134 waivers (from 1981 through 1983), individual waivers for disabled individuals known as "Katie Beckett" waivers) were approved on a case-by-case basis by a DHHS review board. The board ceased to accept new applications after January 1, 1985. States requesting a model waiver must determine that the individuals would have required institutional care, that care at home is appropriate, and that the estimated cost of noninstitutional care is no more than

Table 4.3

Medicaid coverage under Supplemental Security Income, by jurisdiction: March 1983

Medicaid jurisdiction[2]	Included in SSI[1] State plan		Optional categorically needy				
			State supplement recipients				
	All SSI recipients	More restricted standard	Aged	Blind	Disabled	Persons eligible for but not receiving aid	Persons eligible except for insitutional status
Alabama	x		x	x	x		x
Alaska	x		x	x	x	x	x
Arkansas	x						x
California	x		x	x	x		
Colorado	x		x				x
Connecticut		x	x	x	x	x	
Delaware	x					x	x
District of Columbia	x					x	x
Florida	x						x
Georgia	x						x
Hawaii		x	x	x	x	x	x
Idaho	x		x	x	x	x	x
Illinois		x	x	x	x		
Indiana		x					
Iowa	x			x			x
Kansas	x						
Kentucky	x						
Louisiana	x						x
Maine	x		x	x	x		x
Maryland	x					x	
Massachusetts	x		x	x	x	x	x
Michigan	x		x	x	x		
Minnesota		x	x	x	x		x
Mississippi	x						x
Missouri		x		x			
Montana	x		x	x	x	x	x
Nebraska		x	x	x	x		
Nevada	x		x	x			x
New Hampshire		x	x	x	x	x	x
New Jersey	x		x	x	x	x	x
New Mexico	x						x
New York	x		x	x	x	x	x
North Carolina		x				x	
North Dakota		x				x	
Ohio		x					
Oklahoma		x	x	x	x	x	x
Oregon	x		x	x	x	x	x
Pennsylvania	x		x	x	x	x	x
Rhode Island	x		x	x	x	x	x
South Carolina	x						x
South Dakota	x						x
Tennessee	x						x
Texas	x						x
Utah		x				x	x
Vermont	x		x	x	x	x	
Virginia		x	x	x	x	x	x
Washington	x		x	x	x	x	x
West Virginia	x					x	x
Wisconsin	x		x	x	x	x	x
Wyoming	x						x

[1] Supplemental Security Income.

[2] Eligibility determination for the territories is based on separate regulations which are found in 42 Code of Federal Regulations, Part 436. The Medicaid agency may not require a separate application for Medicaid from individuals receiving cash assistance under a State plan for Old Age Assistance, Aid to Families With Dependent Children, Aid to the Blind, Aid to the Permanently and Totally Disabled, or Aid to the Aged, Blind, and Disabled.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Unpublished data.

that of institutional care. As of September 1984, requests for 22 model waivers have been received from 15 States; 11 of these from 9 States had been approved.

The medically needy

The medically needy program is one of the most important overall options for coverage that can be exercised under the Medicaid program. The general intent of the medically needy option is to accommodate individuals who meet all criteria for categorically needy assistance with the exception of income and who have incurred relatively large medical bills (Figure 4.2). Since 1969, a State's medically needy income standard has been limited to 133 1/3 percent of the maximum AFDC assistance payment for a family of the same size. For Federal matching purposes, this means the Federal Government recognizes as medically needy only those persons whose "countable" income does not exceed 133 1/3 percent of the maximum payment standard set by the State. Table 4.2 shows the annual income levels for the medically needy in those States with such a program.

Each State is required to employ a single statewide income standard when determining eligibility for medically needy individuals and families. (Although this requirement was removed by OBRA-81, which allowed States to vary their medically needy income standard from one covered group to the next, the single statewide income standard requirement was reinstated by section 137 of TEFRA.)

Under the medically needy spend-down provision (42 CFR 435.831), persons or families with incomes above the medically needy income standard can deduct certain incurred medical expenses for purposes of determining their countable income. Included in these deductible medical services are: (1) Medicare and other health insurance premiums, deductibles, and coinsurance charges; expenses incurred for medical and remedial services included in the Medicaid State plan; and expenses incurred for services not included in the State plan but recognized under State law.

State-only coverage

A State may extend Medicaid coverage to individuals other than those in the preceding groups only at its own expense. The Federal Government will not provide matching assistance in such cases. These groups are referred to as noncategorically medically needy or "State-only" eligibles. They include (1) individuals who are receiving, or are eligible for, general assistance under a statewide program; (2) persons 21-65 years of age who have "sufficient" income and resources to meet daily needs, but not medical expenses, and who are ineligible for Medicaid under the SSI or AFDC categories; and (3) persons with incomes above the Federally established maximum for medically needy groups. Persons covered fully at State expense need not meet any of the requirements for categorical eligibility. For example, a young, single male above the age of 21 and living alone could, at State option, receive Medicaid benefits as a State-only eligible.

Figure 4.2
Eligibility coverage of the medically needy: October 1, 1982

Eligibility criteria for the medically needy:

- Member categorically related group
- Income standard met or income more than allowed but medical expenses incurred are at least equal to the difference between income and the applicable income standard
- Resource standard

Populations for which coverage is:

Mandatory

- All pregnant women during the course of their pregnancy (42 CFR 435.301 b 1 (i))
- All individuals, or reasonable classifications of those individuals, under age 21 (42 CFR 435.308)
- Blind and disabled individuals eligible in December 1973 (42 CFR 435.340)

Optional

- Caretaker relatives (42 CFR 435.310)
- Aged (42 CFR 435.320)
- Blind (42 CFR 435.322)
- Disabled (42 CFR 435.324)
- Aged, blind, and disabled in States imposing more restrictive eligibility requirements than Supplemental Security Income (42 CFR 435.330)

NOTE: CFR=Code of Federal Regulations

Recipients

Data on Medicaid recipients are presented by maintenance assistance status, eligibility category, and demographic characteristics. Table 4.4 shows the percent distribution of Medicaid recipients by basis of eligibility and maintenance assistance status in FY 1982. Individuals eligible for Medicaid are classified into two major groups according to their maintenance assistance status. "Cash assistance recipients" are those who receive cash assistance for their basic necessities under public assistance programs. "Medical assistance only" individuals are those who do not receive cash assistance. This group includes both "medically needy" and "categorically eligible" persons not receiving cash assistance. In FY 1982, there were approximately 21.6 million Medicaid recipients, the majority of whom (74.6 percent) received cash assistance.

Within the two cash assistance groups, persons receiving Medicaid services are classified by basis of eligibility. Eligibility groups are: (1) age 65 or over, (2) blind, (3) disabled, (4) dependent children under age 21, and (5) adults in families with dependent children. Some States extend Medicaid coverage to persons not falling into any of the above categories. Such persons, classified as "other Title XIX recipients," do not receive cash assistance. State-only eligibles are not included in Table 4.4.

The number of Medicaid recipients in each jurisdiction in FY 1981 and 1982 is shown in Table 4.5. Programs are ranked by percent of total recipients. The cumulative percent of national recipients is presented as well. The table also shows the distribution of recipients by eligibility category. During FY 1982, 69 percent of all recipients were in the AFDC category, and 15 percent were in the aged group. Cumulatively, six programs—California, New York, Puerto Rico, Michigan, Pennsylvania, and Illinois—accounted for nearly 50 percent of all Medicaid recipients in FY 1982, and 17 programs served 75 percent of all recipients.

Table 4.6 shows the age, sex, racial and ethnic distributions of recipients for each Medicaid program. During FY 1982, 50.2 percent of total recipients were under 21 years of age and 17.4 percent were 65 years of age and over. Females accounted for 64.0 percent of all recipients.

Table 4.4

Number and percent distribution of Medicaid recipients by maintenance assistance status and basis of eligibility: Fiscal year 1982

Basis of eligibility	Number of recipients in thousands	Maintenance assistance status	
		Cash assistance	Medical assistance only
		Percent distribution	
Total	21,603.2	74.6	25.4
Age 65 or over	3,239.7	56.2	43.8
Blind	84.3	86.3	13.7
Disabled	2,806.3	78.1	21.9
Dependent children under age 21	9,563.5	85.7	14.3
Adults in families with dependent children	5,356.2	81.7	18.3
Other Title XIX	1,433.7	NA	100.0

SOURCE: Health Care Financing Adminstration, Office of the Actuary: Unpublished data.

Service coverage and limitations

Title XIX regulations require each Medicaid program to offer a basic set of services to all categorically needy persons. States receive Federal financial participation (FFP) for these basic services as well as certain optional services they may elect to cover. States may limit the scope of coverage for both required and optional services, but they must make service coverage uniform throughout their State.

(This "statewideness" rule may be waived for a limited period of time for the purpose of conducting special demonstration studies. OBRA-81 also authorizes waivers of statewideness for federally approved section 2176 home and community-based service programs.)

All States participating in Medicaid must cover the following basic services for all categorically needy recipients:

- Inpatient hospital services, other than services in an institution for tuberculosis or mental disease, that are ordinarily furnished in a hospital for the care and treatment of inpatients, and that are provided under the direction of a physician or dentist. The hospital must be: (a) licensed or formally approved as a hospital by a designated State standard-setting authority, and (b) either qualified to participate under Medicare or determined to currently meet the requirements of participation. It must also have in effect a hospital utilization review plan applicable to all patients who receive medical assistance under the Medicaid program (42 CFR 440.10).
- Outpatient hospital services, including preventive, diagnostic, therapeutic, rehabilitative, or palliative services furnished to a hospital outpatient by or under the direction of a physician or dentist. The hospital must meet the same requirements as for inpatient services; that is, it must be licensed or formally approved as a hospital and must be qualified to participate under Medicare or must meet the requirements for such participation (42 CRF 440.20(a)).
- Rural health clinic services in certified clinics furnished by a physician or (except in States where those professionals are prohibited by State law from furnishing primary health care) by a physican's assistant, nurse practitioner, nurse midwife, or other specialized nurse practitioner (42 CRF 440.20(b)).
- Other laboratory and X-ray services, including professional and technical laboratory and radiological services ordered by a physican or other licensed practitioner, within the scope of his or her practice as defined by State law, and provided to a patient by, or under the direction of, a physician or other licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. To be eligible for Medicaid coverage, services must be provided to a patient by a laboratory that is qualified to participate under Medicare or has been determined to meet the requirements for such participation (42 CRF 440.30).
- Skilled nursing facility services for individuals 21 years of age or over, other than services in an institu-

tion for tuberculosis or mental diseases. These services must be ordered by and under the direction of a physician. The facility must be qualified for participation in Medicaid (42 CFR 440.40(a)).

- Physicians' services, whether provided in the office, the patient's home, a hospital, an SNF, or elsewhere. Physicians' services are defined to include services provided within the scope of practice of the profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy (42 CFR 440.50).

Table 4.5

Number of Medicaid recipients, by jurisdiction, rank of jurisdiction, and basis of eligibility: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Number of recipients in thousands	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	AFDC[2]	Other Title XIX recipients
1981				Percent distribution				
All jurisdictions	21,979.6	100.0	100.0	15.5	.4	13.7	67.5	6.2
California	3,616.9	16.5	16.5	15.7	.7	14.6	63.4	7.1
New York	2,241.1	10.2	26.7	15.8	.2	14.3	67.2	9.8
Puerto Rico	1,449.7	6.6	33.3	NA	NA	11.3	45.8	42.8
Illinois	1,110.7	5.1	38.4	7.6	.1	12.7	78.5	1.0
Pennsylvania	1,090.0	5.0	43.4	11.5	.2	11.0	72.3	4.9
Michigan	962.0	4.4	47.8	9.7	.2	11.2	78.2	.8
Ohio	856.7	3.9	51.7	10.6	.3	11.6	82.9	NA
Massachusetts	746.8	3.4	55.1	16.6	.7	10.3	68.5	3.9
Texas	705.8	3.2	58.3	34.2	.5	15.2	54.5	NA
New Jersey	661.1	3.0	61.3	9.4	.2	9.5	80.8	2.1
Florida	539.2	2.5	63.8	21.6	.5	17.5	62.3	NA
Wisconsin	445.2	2.0	65.8	15.0	.2	12.1	71.5	1.2
Georgia	442.9	2.0	67.8	23.9	.7	21.8	61.0	.6
Kentucky	412.8	1.9	69.7	15.7	.5	15.4	69.8	4.8
Louisiana	410.4	1.9	71.6	24.0	.4	17.2	58.3	NA
North Carolina	382.4	1.7	73.3	20.0	.7	13.4	64.5	1.4
Tennessee	364.2	1.7	75.0	22.7	1.2	21.7	54.4	NA
Missouri	361.1	1.6	76.6	20.3	.7	12.1	65.9	1.0
Washington	331.4	1.5	78.1	14.9	.1	19.4	75.9	NA
Virginia	330.9	1.5	79.6	19.7	.4	14.3	68.6	2.0
Alabama	330.6	1.5	81.1	29.7	.6	18.7	61.2	1.6
Mississippi	328.6	1.5	82.6	23.1	.5	16.5	59.7	.2
Maryland	328.2	1.5	84.1	12.0	.1	10.5	77.4	NA
Minnesota	324.0	1.5	85.6	16.6	.2	8.8	67.3	7.0
Oklahoma	277.7	1.3	86.9	19.5	.2	9.6	70.6	.1
South Carolina	271.9	1.2	88.1	30.9	.8	22.6	—	.3
Indiana	222.3	1.0	89.1	15.6	.4	13.6	70.3	NA
Connecticut	222.2	1.0	90.1	15.9	.1	9.6	74.3	.2
Arkansas	219.0	1.0	91.1	27.5	.7	18.7	47.2	7.3
West Virginia	207.4	.9	92.0	15.8	.2	16.5	72.1	NA
Iowa	195.6	.9	92.9	16.6	.5	9.4	75.0	3.8
Oregon	170.6	.8	93.7	10.9	.6	9.1	68.0	11.4
Kansas	148.8	.7	94.4	18.9	.2	10.9	78.3	2.4
Maine	145.5	.7	95.1	16.0	.2	11.8	70.4	1.6
Colorado	145.5	.7	95.8	25.5	.2	11.7	72.6	4.2
Rhode Island	126.6	.6	96.4	18.7	.2	23.5	56.0	1.5
District of Columbia	121.1	.6	97.0	9.5	.1	11.4	79.0	NA
Hawaii	104.5	.5	97.5	11.6	.2	7.3	86.0	.9
New Mexico	94.5	.4	97.9	13.4	.5	16.3	68.1	1.7
Nebraska	76.4	.3	98.2	20.1	.3	12.0	63.7	3.9
Utah	68.1	.3	98.5	11.3	.1	9.3	81.3	5.5
Vermont	56.8	.3	98.8	14.8	.2	11.8	75.4	1.9
Delaware	50.4	.2	99.0	9.9	.2	9.5	77.4	5.3
Montana	49.3	.2	99.2	15.1	1.8	13.2	66.2	3.7
New Hampshire	44.3	.2	99.4	21.9	.8	11.5	77.3	.6
Idaho	42.8	.2	99.6	16.0	.2	14.0	73.7	2.3
South Dakota	35.4	.2	99.8	25.6	.4	14.7	66.3	2.7
North Dakota	32.4	.1	99.9	30.9	.2	12.1	69.1	7.3
Nevada	30.2	.1	100.0	22.4	1.4	15.2	61.2	4.9
Alaska	25.5	.1	100.1	14.7	.4	13.9	70.7	.3
Wyoming	11.4	.1	100.2	17.5	.3	9.9	71.8	.5
Virgin Islands	10.4	.2	100.2	9.1	1.1	2.5	78.2	.1

See footnotes at end of table.

Table 4.5—Continued

Number of Medicaid recipients, by jurisdiction, rank of jurisdiction, and basis of eligibility: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Number of recipients in thousands	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	AFDC[2]	Other Title XIX recipients
1982				Percent distribution				
All jurisdictions	21,603.2	100.0	100.0	15.0	0.4	13.0	69.1	6.6
California	3,747.9	17.3	17.3	15.2	0.7	14.2	65.8	7.1
New York	2,145.1	9.9	27.2	15.8	0.2	14.3	67.2	9.8
Puerto Rico	1,437.7	6.7	33.9	8.0	—	3.3	45.8	42.8
Michigan	1,174.8	5.4	39.3	7.7	0.2	10.2	87.5	0.9
Pennsylvania	1,098.2	5.0	44.3	11.7	0.2	11.5	78.5	5.9
Illinois	1,063.4	4.8	49.1	7.2	0.1	12.8	82.6	0.7
Ohio	878.3	4.0	53.1	10.4	0.2	10.8	82.7	NA
Texas	676.3	3.1	56.2	34.8	0.6	15.5	53.4	0.4
Massachusetts	669.7	3.1	59.3	12.1	0.8	10.3	68.4	3.8
New Jersey	636.3	2.9	62.2	9.5	0.2	9.9	80.9	2.1
Florida	520.1	2.4	64.6	21.2	0.5	18.0	63.0	NA
Wisconsin	459.8	2.1	66.7	11.8	0.2	10.1	75.2	2.7
Georgia	437.7	2.0	68.7	21.8	0.7	20.7	61.5	0.6
Louisiana	388.8	1.8	70.5	23.9	0.4	16.4	57.8	1.4
Tennessee	363.0	1.7	72.2	22.7	1.2	21.8	54.4	NA
North Carolina	353.8	1.6	73.8	21.1	0.6	13.2	63.8	1.4
Kentucky	352.5	1.6	75.4	16.7	0.6	16.4	72.5	1.8
Missouri	338.0	1.6	77.0	20.0	0.7	13.7	64.1	1.6
Maryland	323.2	1.5	78.5	11.8	0.1	10.4	77.8	NA
Minnesota	323.3	1.5	80.0	16.2	0.2	9.1	67.7	6.9
Alabama	321.8	1.5	81.5	28.4	0.6	19.4	55.7	1.5
Virginia	319.0	1.5	83.0	19.5	0.4	14.7	69.6	1.9
Mississippi	303.6	1.4	84.4	22.6	0.6	17.8	58.7	0.3
Washington	253.1	1.2	85.6	20.2	0.2	20.4	74.6	NA
South Carolina	250.1	1.1	86.7	19.4	0.6	19.1	91.9	0.1
Oklahoma	242.7	1.1	87.8	23.8	0.2	10.6	65.3	0.1
Indiana	238.3	1.1	88.9	15.6	0.4	13.6	70.3	NA
Connecticut	197.6	0.9	89.8	14.4	0.1	9.1	71.9	4.4
Arkansas	196.4	0.9	90.7	28.5	0.8	20.4	46.0	6.7
Iowa	179.6	0.8	91.5	16.8	0.5	10.0	71.7	8.1
West Virginia	178.3	0.8	92.3	14.0	0.2	15.4	73.7	NA
Oregon	165.7	0.8	93.1	11.2	0.6	9.9	68.0	10.3
Kansas	147.8	0.7	93.8	17.9	0.2	10.8	77.1	1.5
Colorado	143.7	0.7	94.5	26.1	0.1	12.0	76.3	3.8
Maine	127.1	0.6	95.1	16.8	0.2	13.1	78.8	1.8
Rhode Island	123.9	0.6	95.7	18.7	0.2	23.5	56.0	1.5
District of Columbia	108.4	0.5	96.2	10.3	0.1	12.2	77.1	0.3
Hawaii	102.1	0.5	96.7	11.4	0.2	7.3	86.8	0.9
New Mexico	90.6	0.4	97.1	13.5	0.5	17.3	66.9	1.8
Nebraska	77.7	0.4	97.5	18.9	0.3	11.6	65.4	3.8
Utah	59.6	0.3	97.8	11.7	0.1	10.3	75.7	9.5
Vermont	54.2	0.2	98.0	14.2	0.2	11.5	72.1	2.0
Montana	53.1	0.2	98.2	15.1	1.8	13.2	66.2	3.7
Delaware	48.2	0.2	98.4	9.9	0.2	9.7	76.8	5.9
New Hampshire	43.8	0.2	98.6	21.2	0.8	11.9	78.2	0.5
Idaho	39.9	0.2	98.8	16.3	0.2	14.3	73.1	2.4
South Dakota	35.7	0.2	99.0	25.1	0.4	15.2	62.4	4.6
North Dakota	31.1	0.1	99.1	34.8	0.2	13.0	65.6	7.5
Nevada	28.7	0.1	99.2	22.3	1.4	15.5	61.1	4.6
Alaska	25.7	0.1	99.3	14.8	0.4	13.9	70.7	0.3
Virgin Islands	15.8	0.1	99.4	9.1	0.1	2.5	78.2	0.1
Wyoming	12.2	0.1	99.5	20.4	0.8	8.3	82.3	0.2

[1]The sum of percentages by basis of eligibility may exceed 100 percent because a recipient may be counted in more than one eligibility group.
[2]Aid to Families With Dependent Children.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Table 4.6

Percent distribution of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1982

Medicaid jurisdiction	Number of recipients in thousands	Age			Sex		Race or ethnic origin				
		Under 21 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent distribution									
All jurisdictions	21,603.2	50.2	32.4	17.4	36.0	64.0	47.7	33.8	.7	.9	16.9
Alabama	321.8	39.2	28.3	32.5	32.9	67.1	38.8	61.0	—	—	.2
Alaska	25.7	—	—	—	—	—	—	—	—	—	—
Arkansas	196.4	39.5	26.3	34.2	34.9	65.1	54.1	45.7	—	.1	.1
California	3,747.9	48.2	32.4	19.3	37.5	62.5	—	—	—	—	—
Colorado	143.7	49.3	29.1	21.5	35.1	64.9	54.0	10.9	.7	.2	34.3
Connecticut	197.6	49.6	29.0	21.4	34.6	65.3	65.2	34.8	—	—	—
Delaware	48.2	60.5	29.8	9.7	34.7	65.3	43.0	52.1	.1	.5	4.4
District of Columbia	108.4	51.4	36.5	12.1	32.9	67.3	3.1	96.7	.1	.1	—
Florida	520.1	46.4	28.0	25.6	32.4	67.6	50.2	47.2	—	.2	2.5
Georgia	437.7	45.2	28.8	26.1	33.3	66.7	35.8	64.1	—	.1	.1
Hawaii	102.1	58.7	30.9	10.4	40.5	59.5	24.7	.9	—	72.9	1.4
Idaho	39.9	54.3	29.8	15.8	34.6	65.4	89.6	.7	.7	2.8	6.3
Illinois	1,063.4	57.2	33.5	9.3	36.6	63.4	36.7	54.0	.1	.6	8.6
Indiana	238.3	—	—	—	—	—	—	—	—	—	—
Iowa	179.6	53.3	29.8	16.9	35.3	64.7	90.2	7.2	.5	1.1	1.0
Kansas	147.8	48.8	32.3	18.9	36.0	64.0	73.4	22.4	.8	—	3.3
Kentucky	352.5	51.0	31.8	17.2	37.2	62.8	82.8	17.2	—	—	—
Louisiana	388.8	44.3	30.2	25.5	34.5	65.5	29.7	70.3	—	—	—
Maine	127.1	49.6	31.6	18.8	37.8	62.2	—	—	—	—	—
Maryland	323.2	53.1	33.7	13.1	34.2	65.8	42.3	57.7	—	—	—
Massachusetts	669.7	46.7	36.4	16.9	32.0	68.0	—	—	—	—	—
Michigan	1,174.8	61.8	30.1	8.1	38.4	61.6	61.4	35.4	.5	.5	3.3
Minnesota	323.3	51.0	30.9	18.1	37.7	62.3	82.9	4.4	3.8	8.0	.9
Mississippi	303.6	47.0	26.2	26.7	33.7	66.3	23.5	76.3	.1	.1	—
Missouri	338.0	42.6	29.0	28.3	33.1	66.9	63.7	36.3	—	—	—
Montana	53.1	44.7	34.5	20.8	36.7	63.3	85.3	.3	12.4	.9	1.1

See footnotes at end of table.

Table 4.6—Continued

Percent distribution of Medicaid recipients, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1982

Medicaid jurisdiction	Number of recipients in thousands	Age			Sex		Race or ethnic origin				
		Under 21 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent distribution									
Nebraska	77.7	50.8	29.8	19.4	35.3	64.7	73.9	18.2	3.3	1.1	3.4
Nevada	28.7	52.0	24.7	23.3	33.0	67.0	85.9	4.2	3.4	.2	6.4
New Hampshire	43.8	46.6	32.8	20.6	33.6	66.4	100.0	—	—	—	—
New Jersey	636.3	59.2	30.1	10.7	34.9	65.1	38.0	42.1	.1	.4	19.4
New Mexico	90.6	48.3	33.8	18.0	35.4	64.6	88.0	4.7	7.4	—	—
New York	2,145.1	50.4	32.0	17.7	35.8	64.2	67.3	26.2	.5	.3	5.7
North Carolina	353.8	47.2	31.2	21.5	32.4	67.6	38.6	59.2	.1	.1	2.1
North Dakota	31.1	47.1	28.4	24.5	36.0	64.0	81.2	.3	17.5	.5	.5
Ohio	878.3	55.1	34.5	10.4	36.7	63.3	67.6	31.2	—	—	1.2
Oklahoma	242.7	47.3	27.7	25.0	35.4	64.6	68.5	23.2	7.3	.2	.8
Oregon	165.7	—	—	—	—	—	—	—	—	—	—
Pennsylvania	1,098.2	55.6	32.6	11.8	37.4	62.6	61.3	33.0	.1	.3	5.4
Puerto Rico	1,437.7	48.2	44.2	7.6	40.0	60.0	—	—	—	—	100.0
Rhode Island	123.9	39.9	28.4	31.7	33.5	66.5	76.6	12.7	.1	4.4	6.2
South Carolina	250.1	46.8	29.9	23.3	30.9	69.1	26.9	72.9	—	.1	—
South Dakota	35.7	47.4	26.9	25.7	35.1	64.9	70.5	.4	29.1	—	—
Tennessee	363.0	—	—	—	—	—	—	—	—	—	—
Texas	676.3	39.9	26.3	33.9	33.8	66.2	40.1	31.1	.1	.6	28.0
Utah	59.6	58.3	30.5	11.2	35.9	64.1	83.9	2.1	3.3	.6	10.1
Vermont	54.2	49.0	35.5	15.5	37.7	62.3	99.2	.2	.1	.5	—
Virgin Islands	15.8	67.6	24.8	7.6	31.6	68.4	—	—	—	—	—
Virginia	319.0	50.1	31.5	18.4	34.3	65.7	43.2	55.9	.1	.6	.3
Washington	253.1	51.4	33.4	15.2	35.1	64.9	81.5	8.2	3.7	2.7	3.9
West Virginia	178.3	50.6	35.5	13.9	31.4	68.6	93.7	6.2	.1	—	—
Wisconsin	459.8	51.5	33.7	14.8	38.0	62.0	74.0	18.6	2.8	1.1	3.5
Wyoming	12.2	54.1	29.0	16.9	32.5	67.5	83.0	3.1	1.2	.2	12.4

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for recipients under age 21. Included are screening and diagnostic services to determine physical or mental defects as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (42 CFR 440.40(b)).
- Family planning services and supplies for individuals of childbearing age who are eligible for Medicaid and desire such services and supplies (42 CFR 440.40(c)).
- Home health services provided in the patient's residence by a licensed agency. These include nursing services provided on a part-time or intermittent basis by a home health agency (or by a registered nurse when there is no home health agency in the area); home health aide services provided by a home health agency; and medical supplies, equipment, and appliances suitable for use in the home (42 CFR 440.70 and 42 CFR 441.15).

As of October 1, 1981, States with a medically needy program must cover the following services for medically needy recipients (42 CFR 440.220): (1) prenatal care and delivery services for pregnant women, (2) ambulatory services as defined in the State plan for individuals under age 18 and individuals entitled to institutional services, and (3) home health services (42 CFR 440.70) for any individual entitled to SNF services.

In addition to federally required services, each State may offer coverage of certain optional services:

- Medical or other remedial care provided by licensed practitioners within the scope of practice as defined under State law. These practitioners may include, among others, chiropractors (limited coverage), optometrists, and podiatrists (42 CFR 440.60).
- Home health services in addition to those required under 42 CFR 440.70. Specifically included are physical therapy, occupational therapy, speech pathology, and audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services (42 CFR 440.70 (b)(4)).
- Private-duty nursing services, defined as nursing services provided by a professional registered nurse or a licensed practical nurse, under the general direction of the patient's physician. Services may be provided to a patient in his or her own home or in a hospital or SNF when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF (42 CFR 440.80).
- Clinic services, that is, preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but is organized and operated to provide medical care to outpatients (42 CFR 440.90).
- Dental services, in addition to those required to be provided to persons under 21 years of age in the State's EPSDT program (42 CFR 440.100).
- Physical therapy and related services, including occupational therapy and services for individuals with speech, hearing, and language disorders, and the use of such supplies and equipment as are necessary when rendered by, or under the supervision of, an individual qualified (licensed, registered, or certified, as appropriate) in the practice of the appropriate profession, and under the prescription or referral of a physician (42 CFR 440.110).
- Prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses. Prescribed drugs which may be provided are simple or compounded substances or mixtures of substances prescribed by a physican or other licensed practitioner (42 CFR 440.120).
- Other diagnostic, screening, preventive, rehabilitative services (42 CFR 440.130).
- Inpatient hospital services, SNF services, and ICF services to persons 65 years of age or over in institutions for tuberculosis or mental disease (42 CFR 440.140).
- ICF services, other than services in an institution for tuberculosis or mental disease, for the physically ill or mentally retarded (42 CFR 440.150).
- Inpatient psychiatric hospital services for persons under age 21 (42 CFR 440.160).
- Nurse-midwife services concerned with management of the care of mothers and newborns furnished by a licensed nurse-midwife within the scope of practice authorized by State law (42 CFR 440.165).
- Other medical or remedial care recognized under State law. Such additional items and services include transportation, emergency hospital services, personal care services (non professional) prescribed by a physician and performed under the supervision of a registered nurse in the home, Christian Science sanatoriums and nursing services, and SNF services for persons under 21 years of age (42 CFR 440.170).
- Home and community-based services (under waiver agreement) that an individual would need to avoid institutionalization (42 CFR 441, subpart G).

The optional services each State offers to both the categorically and medically needy are shown in Table 4.7. More than 90 percent of the 54 States and territories offer prescribed drug services and/or ICF services. Prosthetic devices, ICF services for the mentally retarded, and SNF services for persons under age 21 are offered by at least 80 percent of the States. Most other optional services are offered by at least 40 percent of the States. Services that are covered by less than 40 percent of the States include Christian Science nurses and sanatoriums, private-duty nursing, personal care services, preventive and screening services, and inpatient hospital, SNF, and ICF services for persons age 65 or older in institutions for tuberculosis.

Once a State has selected a benefit package, Federal regulations require that the State plan specify the amount or duration of each covered service. Such items must be sufficient in amount, duration, and scope to reasonably achieve their purpose (42 CFR 440.230) and comparable for all categorically needy recipients and within each medically needy group (42 CFR 440.240). States may not impose limits on the basis of "diagnosis, type of illness, or condition." Within these general guidelines, States are free to set whatever service limits they choose.

Table 4.7

Medicaid services, by jurisdiction: October 1, 1983

Medicaid recipients receiving federally supported financial assistance must receive at least these services:
- Inpatient hospital services
- Outpatient hospital services

Basic required Medicaid services
- Rural health clinic services
- Other laboratory and X-ray services
- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis, and treatment for individuals under 21
- Family planning
- Physician services.

Optional services in State Medicaid programs

FMAP[1]	● CN[2] + Both CN and MN[3] Basic required Medicaid services See above		Podiatrists' services	Optometrists' services	Chiropractors' services	Other practitioners' services	Private duty nursing	Clinic services	Dental services	Physical therapy	Occupational therapy	Speech, hearing, and language disorder	Prescribed drugs	Dentures	Prosthetic devices	Eyeglasses	Diagnostic services	Screening services	Preventive services
71	●	Alabama		●									●		●	●			
50	●	Alaska		●				●				●				●			
61		Arizona*																	
74	+	Arkansas		+	+	+		+	+				+	+	+	+			
50	+	California	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+
50	●	Colorado	●	●				●	●				●			●			
50	+	Connecticut	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
50	●	Delaware	●			●		●	+		+	+	●	+	●		●	+	
50	+	D C	+	+		+		+		+			+		+	+	+		+
56	●	Florida		●		●			●			●	●	●	●	●			
67	●	Georgia	●			●		●					●		●				
50	+	Guam		+				+					+	+	+	●			
50	+	Hawaii	+	+		+		+	+	+	+	+	+	+	+	+	+	+	+
67	●	Idaho	●	●	●			●		●			●						
50	+	Illinois	●	+	●	●	+	+	+	●	+	●	+	+	+	+	+		+
60	●	Indiana	●	●	●		●	●	●	●	●	●	●	●	●	●	●		●
55	●	Iowa	●	●	●	●		●	●	●	●	●	●	●	●	●			
51	+	Kansas	+	+	+	+	+	+	+	+	+	+	+	+	+	+			
71	+	Kentucky		+		+		+	+	+	+	+	+		+		●	●	●
64	+	Louisiana	+	+	+			+					+	+	+	+			
71	+	Maine	+	+	+	●		+	+	+	+	+	+		+		+	+	+
50	+	Maryland	+	+				+	+	+		+	+	+	+	+			
50	+	Massachusetts	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+
50	+	Michigan	+	+	+	+		+	+	+	+	+	+	+	+	+	+		
53	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
78	●	Mississippi		●				●	●				●		●	●		●	
61	●	Missouri	●	●	●			●	●	●	●	●	●	●	●	●			
64	+	Montana	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+
57	+	Nebraska	+	+	+	+	+	+	+	+		+	+	+	+	+			
50	●	Nevada	●	●	●	●	●	●	●	●	●	●	●	●	●	●			
59	+	New Hampshire	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+
50	●	New Jersey	●	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●
69	●	New Mexico	●	●		●		●	●	●			●	●	●	●			
50	+	New York	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+
68	+	North Carolina	+	+	+			+	+				+	+		+	+	+	+
51	+	North Dakota	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+
50	+	N Mariana Islands		+				+	+	+			+	+	+				
55	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●			
58	+	Oklahoma	+						+				+		+				
57	●	Oregon	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●
56	+	Pennsylvania	+	+	+	+		+	●				●	●	●				
50	+	Puerto Rico				+		+	+	+	+	+	+				+	+	+
58	+	Rhode Island	●	+					+				+	+	+	●			
71	●	South Carolina	●		●			●					●		●				
69	●	South Dakota			●			●	●	●			●	●	●				
71	+	Tennessee						+	●				+		●	●			
54	●	Texas	●	●	●	●							●		●	●			
68	+	Utah	+	+		+	+	+	+	+		+	+	+	+	+			
69	+	Vermont	+	+	+	+		+					+		+	+			
50	+	Virgin Islands						+	+	+	+	+	+	+	+	+			
57	+	Virginia	+	+				+	+	+	+	+	+			+	+		
50	+	Washington	+	+	●	+	+	+	●	+	+	●	+	+	+	+	●		+
71	+	West Virginia	+	+	+	+	+	+		+		+	+	+	+	+			
57	+	Wisconsin		●	●	+	+	+	●	+	+	+	+	●	+	●	+	+	+
50	●	Wyoming		●				●		●					●				
●	20	●	16	17	14	12	4	17	16	12	7	11	19	12	19	18	6	3	4
+	34	+	24	29	15	21	14	32	26	24	20	22	33	24	29	24	17	14	16
	54	**Total**	40	46	29	33	18	39	42	36	27	33	52	36	48	42	23	17	20

[1]Federal Medicaid assistance percentage(FMAP):Rate of Federal financial participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Percentages are rounded and effective as of October 1, 1983.
[2]Categorically Needy: People receiving federally supported financial assistance.
[3]Medically Needy: People who are eligible for medical but not for financial assistance.
[4]Arizona operates a medical assistance program under a Section 1115 demonstration project.

Table 4.7—Continued
Medicaid services, by jurisdiction: October 1, 1983

Federal financial participation is also available to States electing to expand their Medicaid programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Basic required Medicaid services

Optional services in State Medicaid programs

● CN[2]
+ Both CN and MN[3]

FMAP[1]	Basic required Medicaid services See above		Rehabilitative services	Services for age 65 or older in TB institutions: A. Inpatient hospital services	B. SNF[4] services	C. ICF[5] services	Services for age 65 or older in mental inst.: A. Inpatient hospital services	B. SNF services	C. ICF services	Intermediate care facility services	ICF for mentally retarded	Inpatient psychatric service for under age 22	Christian science nurses	Christian science sanitoria	SNF for under age 21	Emergency hospital services	Personal care services	Total additional services
71	●	Alabama		●				●	●	●	●	●	●			●	●		12
50	●	Alaska					●			●	●	●				●	●		10
61		Arizona*																	
74	+	Arkansas		+	+	+	+	●	●	●	●	+				●	+	●	21
50	+	California	+	+	+	+	+	+	+	+	+	+	+	+		+	+		30
50	●	Colorado					●	●	●	●	●	●				●	●		14
50	+	Connecticut	+				+			+	+	+		+		+			24
50	●	Delaware					●		●	●	●					●	●		17
50	+	D C	+	+			+			+	+	+				+	+	+	19
56	●	Florida		●			●			●	●			●			●		14
67	●	Georgia		●	●	●		●	●	●	●					●			13
50	+	Guam																	6
50	+	Hawaii	+							+	+					+	+		20
67	●	Idaho	●						●	●	●					●	●		12
50	+	Illinois	+	+	+	+	+	+	+	+	+	●		+		●	+		29
60	●	Indiana	●				●			●	●	●	●	●		●	●		24
55	●	Iowa	●				●			●	●	●				●			19
51	+	Kansas	+					+	+	+	+	+				+	+	+	23
71	+	Kentucky	●	+			+	+	+	+	+	+				+	+		22
64	+	Louisiana	+	●			●	●	●	●	●	●				●			17
71	+	Maine	+				+	+	●	+	+	+	+	+		+	●		25
50	+	Maryland		+			+		+	+	+					+	+	+	18
50	+	Massachusetts	+	+			+	+	+	+	+		+	+		+	+	+	28
50	+	Michigan					+	+	+	+	+	+		+		+	+	+	24
53	+	Minnesota	+	+	+	+	+	+	+	+	+	+		+		+	+	+	31
78	●	Mississippi		●			●			●	●	●		●		●	●		15
61	●	Missouri		●			●			●	●								16
64	+	Montana	+				+	+	+	+	+	+				+	+	+	26
57	+	Nebraska					+	+	+	+	+	+				+	+	+	22
50	●	Nevada					●	●	●	●	●					●	●	●	22
59	+	New Hampshire	+				+		●	●	●		+	+		+	+	+	26
50	●	New Jersey	●				●	●	●	●	●	●		●		●	●		26
69	●	New Mexico	●							●	●					●	●		15
50	+	New York	+	+	+	+		+	+	+	+	+				+	+	+	28
68	+	North Carolina	+	+			+		+	+	+	+				+			19
51	+	North Dakota	+				+			+	+	+				+	+		23
50	+	N Mariana Islands																+	8
55	●	Ohio	●				●	●	●	●	●	●		●		●	●		24
58	+	Oklahoma	+				+			+	+	+				+		+	11
57	●	Oregon	●				●			●	●	●		●		●	●	●	25
56	+	Pennsylvania					+	+	+	+	+	+				+	+		17
50	+	Puerto Rico	+														+		12
58	+	Rhode Island					+			●	●					+			11
71	●	South Carolina		●			●			●	●	●				●	●		12
69	●	South Dakota						●	●	●	●					●	●	●	14
71	+	Tennessee		+	+	+	+	+	+	+	+	+		●			●		17
54	●	Texas	●	●						●	●			●			●	●	14
68	+	Utah					+	+	+	+	+	+				+	+		20
69	+	Vermont					+			+	+	+				+	+		14
50	+	Virgin Islands																	9
57	+	Virginia		+			+	+	+	+	+			●		+	+	+	20
50	+	Washington	+	+	+	+	+	+	+	+	+	+				+	+		28
71	+	West Virginia								+	+					+	+		16
57	+	Wisconsin	+				●			+	+	●	+	+		+	+	+	26
50	●	Wyoming	●							●						●			7
●	20	●	10	8	1	1	15	9	13	24	23	13	1	8	20	18	5		
+	34	+	19	13	7	7	24	16	17	26	26	20	5	10	26	24	14		
	54	**Total**	29	21	8	8	39	25	30	50	49	33	6	18	46	42	19		

NOTE: The data shown were reported by individual States and compiled by the Office of Intergovernmental Affairs.

SOURCE: Department of Health & Human Services, Health Care Financing Administration, Office of Intergovernmental Affairs

Limitations in services imposed by States for four mandatory services—inpatient hospital, outpatient, home health, and physician's services—and one optional service—long-term care—are presented in Table 4.8. Forty-five States (including the District of Columbia) limit inpatient hospital services; 38 States limit outpatient hospital services and 43 physicians' services. Of services authorized under home health care, 34 States limit part-time nursing services, 35 limit aide services; 40 either limit or do not cover physical, occupational, speech, and hearing therapy; and 44 limit medical supplies and equipment. Twenty-nine States limit services covered in ICF's and 27 either do not offer or limit services covered in ICF-MR's.

The limitations imposed by States on prescription drugs as of March 1983 are shown in Table 4.9. Seventeen States imposed a fixed or variable copayment on each prescription; 10 limited the number of prescriptions per recipient; and 19 limited the number of refills per prescription. Three States imposed a dollar (as opposed to quantity) limit on prescription costs: Florida, $22 per month; Idaho, $30 per month; and Pennsylvania, $15 per month. Twenty-five States limited the size of each prescription. All but 9 excluded most or all over-the-counter drugs from coverage, and all but 7 employed formulary restrictions of varying stringency.

Prior to October 1, 1982, States were permitted to charge Medicaid recipients copayments except for mandatory services provided to the categorically needy. Section 131 of TEFRA now enables States to charge both categorically and medically needy recipients copayments, except for the following: services provided to individuals under age 18 (or up to age 21 at State option); services related to pregnancy (or any services provided to pregnant women); services furnished to institutionalized individuals who are required to expend all of their income above their personal needs allowance; emergency services; and family planning services and supplies.

Utilization

This section presents data on the use of medical services by Medicaid recipients. Tables show the distribution of Medicaid recipients by type of medical service, number of recipients, and volume of services received for general hospitals, SNF's, ICF's, physicians' services, and drug prescriptions. Recipient counts for each type of service are unduplicated. However, recipients who received more than one type of service are counted for each type of service they received. For example, the same recipient may have used inpatient hospital services, physicians' services, and outpatient hospital services. Thus, the total number of unduplicated recipients will generally be less than the sum of recipients that receive each service.

Medicaid recipient and service statistics are not presented as rates per 1,000 eligibles (''population at risk''), as are the Medicare data presented in Chapter 3. Instead, they represent average use by those who actually received services. (No national counts of Medicaid eligibles are available at present, although work is in progress to develop unduplicated counts of eligibles.) The number of recipients in each jurisdiction in FY 1981 and 1982, along with the percentage of total recipients who used specific services, are shown in Table 4.10. Because a recipient can receive more than one service, the sum of individual percentages may exceed 100 percent.

The number of Medicaid recipients and total vendor payments in FY 1982 (excluding territories), by type of medical service and by recipients' age, sex, and race or ethnicity, is shown in Table 4.11. Recipients under 21 years of age comprised 50.4 percent of total recipients. These individuals were proportionally low users of specific services except for dental (63.8 percent) and clinic (54.2 percent) services. Recipients 21-64 years of age constituted 31 percent of all recipients and used substantially higher than average proportions of family planning, laboratory and radiological, and inpatient hospital services. Those aged 65 years or over used proportionally more SNF, ICF, and home health services. Females equaled or exceeded their proportion of the recipient population in the use of virtually every service.

Recipients under 21 years of age accounted for 20 percent of total Medicaid payments but nearly 55 percent of all payments for dental services. Recipients 21-64 years of age accounted for 75 percent of all payments for family planning services, and those aged 65 or over accounted for more than 80 percent of both SNF and ICF payments.

The number of recipients and total days of care in general hospitals, SNF's, and ICF's (other than intermediate care facilities for the mentally retarded), along with the number of physician visits and number of outpatient drugs dispensed to Medicaid recipients for FY 1981 and FY 1982, are shown by jurisdiction in Table 4.12. For general hospitals, total discharges are a count of hospital stays, but recipients discharged are an unduplicated count of persons. A day of care in general hospitals, SNF's, or ICF's is counted only if paid for, in whole or in part, by Medicaid. As a result, it is not possible to derive average lengths of stay for Medicaid patients from these data alone.

A physician visit is defined as a consultation with a physician or a person acting under the physician's supervision. When a physician's bill does not show visits but simply a flat fee, the recipient is reported as receiving physicians' services but the number of visits is not reported. The number of prescriptions includes refills, but covers only drugs dispensed outside hospitals or other inpatient facilities.

Table 4.8

Limits on selected Medicaid services, by jurisdiction: March 1983

Medicaid jurisdiction	Inpatient hospital services										Outpatient hospital services						Home health services				Long-term care services	
	Inpatient hospital	Elective procedures	Specific procedures	Elective surgery	Procedures that could be outpatient	Weekend admissions, preoperation days	Dental procedures	Some optional services	Sterilization	Other	Outpatient hospital	Special procedures or services	Specific procedures or services	Psychiatric	Sterilization	Other	Part-time nursing	Aide	Medical supplies or equipment	Phys., occup., speech, hearing therapy	Intermediate care facility	Intermediate care facility for the mentally retarded
Alabama	MAX 15		PAR			LD	LD			OLD	MVR 6		PAR				PAR VLD	PAR VLD	RSL	NP	PAR	PAR
Alaska		PAR	PAR							OLD							PAR	PAR	PAR	PAR	PAR	PAR
Arkansas										OLD	MVR 12									LDS	PAR	PAR
California			PAR NC		NC							NC				OLD	PAR	PAR VLD	PAR	PAR VLD	PAR PRR	PAR PRR
Colorado										OLD		NC					PAR	PAR	PAR	PAR	PAR PRR	PAR PRR
Connecticut			NC									NC				OLD	OLD	VLD				
Delaware																						
District of Columbia			PAR				LD			OLD			PAR			OLD			PAR RSL	OLD		
Florida	MAX 45		NC	NC							MVR 12	NC				OLD			LDQ RSL	NP		
Georgia	MAX 25		PAR			LD		LD	LD							OLD	VLD	VLD	PAR RSL	PAR OLD	PAR	PAR
Hawaii			PAR							OLD				LD					PAR		PAR	PAR
Idaho											MVR 6						VLD	VLD	PAR OLD	LDS		
Illinois					NC	LD											PAR	PAR	PAR	PAR		
Indiana			PAR										PAR				PAR	HNC	PAR	PAR LDS	OLD	OLD
Iowa			PAR NC				LD	NC								OLD			OLD	LDS		
Kansas			NC			LD				OLD		NC	PAR	LD		OLD	OLD	HNC	PAR OLD	LDS OLD	OLD	OLD
Kentucky	MSP 14		NC		NC	LD				OLD						OLD	OLD	HNC	PAR	LDS	PAR	PAR
Louisiana	MAX 15			PAR					PAR	OLD		PAR			PAR	OLD	VLD OLD	VLD OLD		LDS OLD		
Maine	MAX 30									OLD												
Maryland	MSP 20		PAR NC			LD		NC		OLD		NC	PAR	LD		OLD	OLD	OLD	OLD	VLD OLD	PAR OLD	
Massachusetts																	OLD	OLD	OLD	OLD	OLD	
Michigan			PAR NC		NC	NC	LD	NC		OLD		NC	PAR	LD		OLD	OLD	OLD	OLD	OLD	PAR PRR	PAR PRR

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1983

Medicaid jurisdiction	Inpatient hospital services										Outpatient hospital services						Home health services				Long-term care services	
	Inpatient hospital	Elective procedures	Specific procedures	Elective surgery	Procedures that could be outpatient	Weekend admissions, preoperation days	Dental procedures	Some optional services	Sterilization	Other	Outpatient hospital	Special procedures or services	Specific procedures or services	Psychiatric	Sterilization	Other	Part-time nursing	Aide	Medical supplies or equipment	Phys., occup., speech, hearing therapy	Intermediate care facility	Intermediate care facility for the mentally retarded
Minnesota										OLD		NC							PAR OLD	OLD		
Mississippi	MAX 30					LD					MVR 18					OLD	VLD OLD	VLD OLD	LDQ	LDS VLD	PAR	PAR
Missouri	OLD		OLD		OLD LD	LD OLD			OLD	OLD	MVR 24		PAR		OLD	OLD	VLD OLD	VLD	OLD	LDS OLD		
Montana																	VLD	VLD	PAR OLD	VLD LDS		
Nebraska			PAR							OLD		NC		LD		OLD		OLD	PAR LDQ		OLD	OLD
Nevada									PAR	OLD	MVR 24		PAR	MVR 24	PAR	OLD	PAR	PAR	PAR	PAR	PAR	PAR
New Hampshire																	VLD	VLD	PAR	VLD LDS	PAR PRR	PAR PRR
New Jersey			NC							OLD		NC	PAR			OLD	PAR	PAR	PAR	PAR	PAR PRR	OLD
New Mexico			PAR							OLD			PAR				PAR OLD	PAR OLD	PAR	PAR OLD		
New York					NC	LD				OLD							PAR	PAR	PAR	PAR	PAR OLD	PAR
North Carolina			PAR					NC		OLD	MVR 24	NC		LD		OLD	OLD	OLD	OLD		PAR	PAR
North Dakota																			OLD	PAR OLD		
Ohio	MSP 30		NC							OLD	MVR 48						VLD	VLD	OLD	NP	PAR	PAR
Oklahoma	MSP 10									OLD						OLD	PAR	PAR	PAR	PAR	OLD	PAR
Oregon	MAX 18		NC									NC	PAR				VLD	VLD	PAR	LDS		
Pennsylvania			NC		NC		LD	NC	LD	OLD		LD	PAR	NC	LD	OLD	PAR	PAR	PAR	PAR	PAR	PAR
Rhode Island			PAR NC							OLD			PAR				VLD VLD	VLD HNC	PAR	VLD LDS	PAR	PAR
South Carolina	MAX 12		PAR NC						LD		MVR 18						OLD VLD		RSL OLD	OLD VLD		OLD
South Dakota	MAX 60																					

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1983

Medicaid jurisdiction	Inpatient hospital services									Outpatient hospital services					Home health services				Long-term care services	
	Inpatient hospital	Elective procedures	Specific procedures	Elective surgery	Procedures that could be outpatient	Weekend admissions, preoperation days	Dental procedures	Some optional services	Sterilization	Other	Outpatient hospital	Special procedures or services	Specific procedures or services	Psychiatric	Sterilization	Other	Part-time nursing	Aide	Medical supplies or equipment	Phys., occup., speech, hearing therapy	Intermediate care facility	Intermediate care facility for the mentally retarded
Tennessee	MAX 14					LD					MVR 30						VLD	VLD	OLD	VLD OLD	OLD	
Texas	MSP 30							NC				NC				OLD	PAR VLD	PAR VLD	PAR OLD		OLD	OLD
Utah			PAR						LD	OLD					LD				PAR OLD	PAR VLD		
Vermont			PAR NC				LD	NC								OLD		OLD	VLD	OLD	OLD	
Virginia	MSP 21					LD				OLD						OLD			PAR RSL			
Washington										OLD							OLD	HNC OLD	PAR	PAR OLD		
West Virginia	MAX 20						PAR				OLD	NC				OLD			PAR	OLD	OLD	OLD
Wisconsin			PAR							OLD			PAR	LD		OLD			OLD	VLD LDS	OLD	OLD
Wyoming			NC														OLD		OLD	OLD		NP

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1983

Medicaid jurisdiction	Inpatient hospital	Long-term care facility	Physician services: Office	Home	Emergency room	Other than inpatient hospital	Specific procedures or services	Elective procedures	Specific settings	Care outside State	Psychiatric	Consultation	Family planning	Comprehensive exam	Hypo-sensitization	Eye exam	Injections	Sterilization	Other
Alabama	VPD 1					MVR 12				PAR	PAR								OLD
Alaska							PAR	PAR										LD	
Arkansas	VPD 2				MVR 12	MVR 12	NC	PAR									LD		
California											PAR LDS 24				LDS 24		LD		
Colorado																			
Connecticut		MVR 4					NC				PAR								
Delaware																			
District of Columbia							NC							LDS 1					
Florida	VPD 1	MVR 2				MVR 36	NC	PAR				LDS 1							OLD
Georgia			MVR 12				PAR NC	PAR	PAR				LDS 2				LD		OLD
Hawaii		MVR 24																	
Idaho							NC			PAR	PAR								
Illinois																			OLD
Indiana																			
Iowa							NC PAR										LD		OLD
Kansas	VPD 1		MVR 36	MVR 12			PAR NC			PAR	PAR LDS 36								
Kentucky							NC				PAR			LDS 1					OLD
Louisiana	VPD 1				MVR 3	MVR 12	PAR					LD						PAR	OLD
Maine																			
Maryland							PAR NC												OLD
Massachusetts								PAR											
Michigan		MVR 12		LD	LO		NC		LD	PAR	MVR 10	LD		LDS		LD			OLD

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1983

Medicaid jurisdiction	Inpatient hospital	Long-term care facility	Physician services: Office	Home	Emergency room	Other than inpatient hospital	Specific procedures or services	Elective procedures	Specific settings	Care outside State	Psychiatric	Consultation	Family planning	Comprehensive exam	Hypo-sensitization	Eye exam	Injections	Sterilization	Other
Minnesota							PAR NC												OLD
Mississippi	VPD 1	MVR 36				MVR 18	NC												
Missouri	OLD	MVR 12			MVR 24		OLD	PAR	OLD	PAR		LD		LDS 1		OLD	OLD	OLD	OLD
Montana							PAR NC									LDS 1			OLD
Nebraska											PAR						LD	LD	
Nevada		MVR 24	MVR 24	MVR 24						PAR	MVR 24	MVR 24					LD 24	PAR	
New Hampshire	MVR 12					MVR 18			PAR										OLD
New Jersey							PAR				PAR								OLD
New Mexico	VPD 2																		OLD
New York																			
North Carolina						MVR 24	PAR				PAR LDS 2					LDS 1			OLD
North Dakota																			
Ohio		MVR 36					NC		PAR										
Oklahoma	VPD 1	MVR 24	MVR 48	MVR 48														LD	OLD
Oregon							NC	PAR		PAR									
Pennsylvania																			OLD
Rhode Island							PAR	PAR	PAR		PAR			LDS 1		LDS 2			OLD
South Carolina		MVR 12	MVR 18				NC					LDS 3							
South Dakota							NC												
Tennessee	VPD 1		MVR 24					PAR											
Texas											PAR								
Utah							PAR												
Vermont		MVR 12					PAR NC	PAR			PAR							LD LD	

See footnotes at end of table.

Table 4.8—Continued

Limits on selected Medicaid services, by jurisdiction: March 1983

Medicaid jurisdiction	Physician services																		
	Inpatient hospital	Long-term care facility	Office	Home	Emergency room	Other than inpatient hospital	Specific procedures or services	Elective procedures	Specific settings	Care outside State	Psychiatric	Consultation	Family planning	Comprehensive exam	Hypo-sensitization	Eye exam	Injections	Sterilization	Other
Virginia							PAR NC				PAR LDS 26								
Washington	VPD 1	MVR 24					NC	PAR			PAR								OLD
West Virginia																			
Wisconsin							PAR NC												
Wyoming		MVR 12					NC							LDS 1			LD		

NOTE: Following is a list of abbreviations used in this table:

MAX - Limit on number of days per year, followed by number of days
PAR - Prior authorization required
PRR - Periodic reauthorization required
LD - Limited
NC - Not covered
MVR - Limit on number of visits per year, followed by number of visits
VLD - Limit on visits per year
VPD - Limit on visits per day, followed by number of visits
LDS - Limit on frequency of service per year, may be followed by number of services
LDQ - Limit on quantity or dollars
RSL - Restricted supply list
HNC - Homemaker services not provided
OLD - Other limits
MSP - Limit on number of days per spell of illness, followed by number of days
NP - Not provided

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy, Medicaid Statistics Branch: Summary Tables, Analysis of Medicaid Program Characteristics, December 1983.

Health Care Financing Administration, Bureau of Data Management and Strategy, and La Jolla Management Corporation: *Analysis of State Medicaid Program Characteristics*. Rockville, Md., 1983.

Table 4.9

Medicaid limits on prescribed drugs, by jurisdiction: March 1983

Medicaid jurisdiction[1]	Copayment level	Maximum prescriptions per month	Maximum refills per month(s)[2]	Maximum quantity per day	Over-the-counter exclusions[3]	Formulary status[4]
Alabama	$0.50-$3.00		5/6	34	B	C
Arkansas		4	5/6	33	B	B
California				100	B	D
Colorado				100	B	C
Connecticut				30-90	B	B
Delaware					B	B
District of Columbia	0.50		3/4		B	B
Florida			[5] 12		B	B
Georgia		6		30	B	B
Hawaii					A	B
Idaho				34	B	B
Illinois					B	D
Indiana					A	A
Iowa	0.50				B	B
Kansas	0.50		[5] 12	30-100	A	A
Kentucky			5/6		B	C
Louisiana			5/6		B	B
Maine	0.50		5/6	180	B	B
Maryland				100	B	B
Massachusetts			5/6	180	B	B
Michigan	0.50				B	C
Minnesota			5/6	30-100	A	A
Mississippi		6	6/1		B	C
Missouri	0.50-2.00				B	C
Montana	0.50-2.00				B	B
Nebraska					B	C
Nevada	1.00	3		30-100	B	B
New Hamshire	1.00			30-100	A	B
New Jersey			5/6	60	A	B
New Mexico				180	B	C
New York			5/6		B	C
North Carolina	0.50	6			B	A
North Dakota			5/12		A	B
Ohio				34	B	A
Oklahoma		3	5/6	34	B	C
Oregon					B	A
Pennsylvania			5/6	34-100	A	B
Rhode Island				30-100	A	B
South Carolina	1.00	3			B	C
South Dakota	1.00				B	B
Tennessee		7	7/1		B	C
Texas		3	5/6	180	B	B
Utah				30-100	B	
Vermont	1.00			60	B	A
Virginia	0.50-1.00				B	B
Washington					B	C
West Virginia	0.50-1.00			30	B	C
Wisconsin	0.50	12	11/12	34	B	C

[1] Alaska and Wyoming do not have drug programs.
[2] Number of refills/number of months.
[3] Over-the-counter (OTC) exclusion codes:
A - All or most OTC drugs reimbursable.
B - Few OTC drugs reimbursable or insulin only.

[4] Formulary status codes:
A - No drug list; all legend drugs reimbursable.
B - No drug list; certain categories excluded from reimbursement.
C - Limited drug list.
D - Restricted drug list.

[5] No limit prescribed within 12 months of original prescription date.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, and La Jolla Management Corporation: *Analysis of State Medicaid Program Characteristics*. Rockville, Md., 1983.

Table 4.10

Percent of Medicaid recipients using selected services, by jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Number of receipients in thousands	Type of service														
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
		General hospital	Mental hospital		Mentally retarded	All other										
1981									Percent							
All jurisdictions	21,979.6	16.9	.4	2.7	.8	3.5	65.5	23.5	16.3	45.6	8.0	17.7	1.8	64.9	6.5	10.4
Alabama	330.6	22.5	.1	2.1	.2	4.9	72.8	13.2	9.1	34.9	—	25.3	1.1	67.6	8.2	15.4
Alaska	25.5	12.2	.8	1.9	1.1	4.9	61.1	19.8	22.4	27.1	2.4	.8	.2	—	2.8	2.9
Arkansas	219.0	21.6	.1	3.0	.7	7.5	75.2	19.7	13.1	37.3	3.2	6.8	.5	78.4	6.1	16.8
California	3,616.9	14.7	.1	3.7	.1	.3	71.1	28.2	20.2	42.2	5.1	22.1	.4	65.3	6.9	12.0
Colorado	145.5	17.2	.4	3.7	1.2	7.2	53.3	16.1	21.9	52.1	39.3	14.1	1.2	67.1	6.4	9.0
Connecticut	222.2	16.1	.8	11.1	—	2.1	65.9	27.1	24.5	51.0	12.6	18.5	11.3	69.5	2.4	17.4
Delaware	50.4	15.3	.2	.2	.9	3.2	74.1	13.4	7.4	48.7	6.0	9.7	1.2	70.4	11.8	.2
District of Columbia	121.1	16.8	—	.5	.3	1.3	60.3	9.5	18.0	50.8	4.3	15.1	2.9	57.8	6.5	2.7
Florida	539.2	19.7	.1	2.6	.3	4.1	71.6	16.2	13.5	42.5	—	4.4	3.4	75.8	4.1	10.2
Georgia	442.9	26.5	—	3.8	.4	4.7	76.4	23.2	8.9	51.0	4.5	6.6	1.1	79.5	8.3	13.9
Hawaii	104.5	12.8	—	2.1	—	1.7	84.9	43.2	8.9	32.1	.4	23.9	.4	71.7	7.1	7.6
Idaho	42.8	15.3	—	4.2	1.2	5.8	68.0	19.7	4.0	40.0	—	39.0	.8	67.7	7.0	16.8
Illinois	1,110.7	19.0	.1	2.3	1.1	4.8	81.1	31.2	24.6	35.5	15.2	20.9	.8	75.2	3.9	5.3
Indiana	222.3	23.5	3.8	—	.9	11.4	43.7	13.4	6.6	26.8	1.9	9.7	.8	89.0	6.3	21.8
Iowa	195.6	17.1	.2	.2	.9	10.4	79.9	37.2	24.2	36.9	2.6	6.4	1.1	72.0	9.7	10.3
Kansas	148.8	19.1	.8	.8	1.3	10.8	74.9	30.2	18.9	42.6	6.5	14.9	.6	72.3	7.5	8.6
Kentucky	412.8	19.0	.1	1.6	.3	4.0	75.5	25.0	9.4	40.6	8.5	5.7	1.7	63.8	7.5	10.5
Louisiana	410.4	14.0	.1	.2	1.1	7.2	68.1	10.2	.1	37.7	2.6	5.8	.3	73.1	8.2	17.8
Maine	145.5	12.1	—	.4	.5	5.9	62.0	24.0	15.1	43.7	2.1	1.2	1.7	64.8	18.2	25.9
Maryland	328.2	16.4	—	—	—	5.1	75.3	24.6	17.5	57.0	—	14.5	.7	70.0	—	3.3
Massachusetts	746.8	25.4	.3	3.1	.4	3.0	69.2	33.2	20.5	42.8	10.2	12.9	2.9	65.3	1.4	19.1
Michigan	962.0	15.7	.7	2.8	.6	3.3	80.0	23.0	15.6	42.5	2.7	20.7	.6	74.9	12.5	8.9
Minnesota	324.0	16.9	.3	8.1	2.1	6.9	75.7	40.9	20.4	35.7	6.4	3.4	3.6	64.2	8.4	18.1
Mississippi	328.6	21.6	—	2.4	.4	2.3	82.3	20.0	4.8	36.7	—	8.7	.9	78.7	9.9	1.9
Missouri	361.1	22.0	—	.5	.6	5.8	58.9	30.1	18.4	44.4	24.2	10.6	.7	72.8	9.6	5.2
Montana	49.3	19.8	—	.9	.5	10.5	82.4	31.9	24.3	39.0	4.7	10.1	1.3	61.8	7.4	11.6
Nebraska	76.4	20.9	.4	1.3	1.2	12.2	72.8	27.9	26.2	37.6	25.3	20.3	1.7	72.5	7.3	5.9
Nevada	30.2	28.7	.1	1.7	.6	8.5	76.5	21.0	10.4	41.6	.9	16.7	1.0	64.6	9.9	17.7
New Hamshire	44.3	16.5	.4	.7	.7	11.3	61.3	24.2	20.7	44.2	7.5	9.3	3.1	68.4	8.2	19.9
New Jersey	661.1	14.1	.5	.6	.8	3.7	73.6	31.8	20.8	42.3	5.4	28.9	1.0	79.5	5.0	10.0
New Mexico	94.5	18.2	—	.2	.6	3.7	71.6	27.8	5.1	40.0	7.0	9.4	1.0	66.6	8.1	16.4
New York	2,241.1	17.1	1.0	3.7	1.5	1.6	60.2	25.7	21.3	46.1	15.6	38.7	8.9	62.5	8.5	12.4
North Carolina	382.4	21.1	.2	3.4	.6	3.4	70.2	27.3	12.8	43.1	8.7	20.4	.9	70.3	7.6	14.8
North Dakota	32.4	25.9	.8	9.2	—	6.9	74.7	33.8	22.9	26.5	4.0	10.8	.3	66.4	.4	10.1
Ohio	856.7	16.7	.1	3.6	.6	3.1	68.9	27.4	22.0	53.6	9.7	9.1	.7	70.8	2.4	7.7
Oklahoma	277.7	20.7	.2	—	.7	8.4	58.5	12.7	4.3	5.8	—	20.2	—	42.5	1.5	14.6
Oregon	170.6	12.3	.7	.5	1.2	6.5	75.5	27.7	7.9	35.2	—	47.3	.3	65.6	7.2	7.9

See footnotes at end of table.

Table 4.10—Continued

Percent of Medicaid recipients using selected services, by jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Number of recipients in thousands	Type of service														
		Inpatient hospital			Intermediate care facility											
		General hospital	Mental hospital	Skilled nursing facility	Mentally retarded	All other	Physicians'	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
1981									Percent							
Pennsylvania	1,090.0	14.4	2.7	3.8	1.0	1.8	61.7	24.6	16.1	50.6	14.6	14.5	1.0	70.0	8.9	1.9
Puerto Rico	1,449.7	3.8	—	—	—	—	—	—	—	99.9	—	—	—	—	—	—
Rhode Island	126.6	15.3	—	.9	.7	5.4	63.6	25.8	19.1	41.7	—	16.2	1.1	67.8	11.8	21.4
South Carolina	271.9	22.8	.1	1.6	.9	3.8	74.0	19.9	12.1	38.9	—	7.0	1.1	70.3	8.1	8.0
South Dakota	35.4	21.6	.5	2.4	2.3	14.5	74.5	14.4	8.9	34.5	6.4	8.5	.4	53.7	6.9	11.6
Tennessee	364.2	28.9	.7	1.3	.7	6.6	67.9	14.3	4.4	30.7	10.9	23.0	1.1	74.8	4.4	4.6
Texas	705.8	23.6	—	1.4	1.8	11.6	80.8	8.4	20.9	32.1	—	28.4	.4	80.2	6.4	13.5
Utah	68.1	15.6	.2	2.0	1.9	5.9	78.5	31.9	17.0	39.1	3.1	20.7	.4	66.8	8.9	7.7
Vermont	56.8	16.5	.3	.5	.7	5.2	75.5	23.6	17.4	45.7	—	40.0	3.6	70.9	9.2	5.5
Virgin Islands	10.4	10.0	—	—	—	—	1.5	3.5	—	87.9	—	.4	.1	72.5	3.0	11.7
Virginia	330.9	19.7	.2	.8	1.5	5.5	78.7	18.7	9.5	46.5	11.5	5.0	.8	73.6	11.5	17.8
Washington	331.4	18.5	.6	6.4	7.6	.4	74.0	28.6	20.4	30.4	2.0	27.2	.9	63.2	5.5	12.2
West Virginia	207.4	17.0	—	.1	.1	2.0	74.6	15.8	11.7	41.5	5.5	8.1	.3	69.5	.8	6.8
Wisconsin	445.2	10.7	.3	9.9	.7	5.9	52.9	42.5	31.5	38.5	46.7	4.4	1.3	73.1	14.1	17.8
Wyoming	11.4	19.2	—	4.6	—	5.5	84.3	12.0	7.3	30.6	—	6.5	.9	—	7.4	16.6
1982																
All jurisdictions	21,603.2	16.4	.3	2.5	.7	3.5	63.9	22.4	14.9	45.9	7.9	18.1	1.8	62.4	6.7	10.9
Alabama	321.8	22.1	—	1.3	.5	5.8	74.1	13.4	9.6	34.9	—	29.8	1.0	69.0	9.3	13.0
Alaska	25.7	12.2	.8	1.9	1.1	4.9	61.1	19.8	22.4	27.1	2.4	.8	.2	—	2.8	2.9
Arkansas	196.4	22.7	.1	3.0	.7	8.5	76.4	14.6	12.2	37.1	3.1	6.1	.8	77.3	5.4	16.2
California	3,747.9	13.6	.1	3.3	.1	.3	69.4	28.0	18.7	44.3	5.4	21.8	.4	64.0	6.6	10.9
Colorado	143.7	18.0	.5	3.6	1.4	7.0	53.6	18.6	23.6	50.8	39.4	14.0	1.7	69.2	7.4	9.2
Connecticut	197.6	14.3	.3	8.2	.7	1.6	62.7	24.9	24.1	51.2	15.4	18.8	2.1	72.7	8.9	16.4
Delaware	48.2	14.9	.2	.2	1.0	3.3	74.5	14.0	7.4	49.2	4.8	8.0	1.3	70.0	11.9	.8
District of Columbia	108.4	16.8	—	.6	.3	1.9	59.5	13.6	3.2	45.5	7.8	20.0	1.8	63.7	8.5	26.3
Florida	520.1	19.1	1.0	2.6	.9	4.4	73.3	16.5	9.6	41.4	—	5.5	6.8	74.9	4.4	15.4
Georgia	437.7	21.7	—	3.7	.4	4.6	74.9	21.0	8.1	44.6	4.1	6.1	1.0	75.5	7.5	12.3
Hawaii	102.1	13.4	—	2.1	.4	1.9	85.6	39.7	8.8	31.0	7.6	24.7	.4	74.1	4.6	6.6
Idaho	39.9	15.4	—	3.9	1.3	6.2	69.0	19.4	4.0	40.0	—	40.3	.8	68.0	7.2	19.6
Illinois	1,063.4	18.5	.1	2.0	.8	4.5	89.1	29.5	17.9	41.6	13.7	21.6	.4	75.5	9.5	7.7
Indiana	238.3	23.5	3.8	—	.9	11.4	43.7	13.4	6.6	26.8	1.9	9.7	.8	89.0	6.3	21.8
Iowa	179.6	16.6	.2	.2	1.0	11.0	78.1	35.7	22.1	37.4	2.4	6.8	1.2	71.5	10.4	10.3
Kansas	147.8	17.9	.6	.7	1.5	10.6	74.6	25.2	16.3	42.4	8.5	18.6	1.0	71.8	9.4	11.2
Kentucky	352.5	18.1	.2	1.6	.5	4.5	76.4	20.0	8.8	39.0	10.2	6.0	1.9	64.0	8.1	2.7
Louisiana	388.8	21.5	.1	.2	1.2	7.3	70.5	11.1	.2	43.6	2.8	7.1	.5	71.1	9.4	18.2
Maine	127.1	25.9	—	.7	.5	7.1	76.8	24.6	19.2	50.9	4.1	2.1	1.9	66.5	7.8	8.2
Maryland	323.2	16.0	—	—	.6	5.4	75.4	23.0	16.9	56.2	—	18.9	.9	70.1	—	3.6

See footnotes at end of table.

Table 4.10—Continued

Percent of Medicaid recipients using selected services, by jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Number of recipients in thousands	Type of service														
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
		General hospital	Mental hospital		Mentally retarded	All other										
1982									Percent							
Massachusetts	669.7	25.4	.3	3.1	.4	3.0	69.1	33.3	20.5	42.8	10.2	12.9	2.9	65.4	1.4	19.2
Michigan	1,174.8	12.6	.2	1.7	.4	3.1	71.1	22.5	14.3	37.9	2.4	19.8	.5	63.2	12.6	14.2
Minnesota	323.3	17.2	.2	8.3	2.3	6.6	75.3	39.9	20.2	35.9	6.4	3.9	3.6	63.8	8.6	18.3
Mississippi	303.6	22.2	—	2.4	.5	2.9	82.0	21.5	4.8	36.9	—	8.8	.6	76.5	9.7	2.1
Missouri	338.0	18.9	.1	.5	.7	6.4	58.4	26.0	13.9	47.5	25.7	14.9	.4	67.7	9.3	5.9
Montana	53.1	19.8	—	.9	.5	10.5	82.4	31.9	24.3	39.0	4.7	10.1	1.3	61.8	7.4	11.6
Nebraska	77.7	20.9	.4	1.3	1.3	11.8	74.3	29.3	27.4	36.6	17.7	21.8	1.5	73.7	7.0	4.9
Nevada	28.7	27.0	.1	1.3	.7	8.6	75.1	19.0	10.2	40.4	2.3	17.5	1.2	66.7	8.7	16.6
New Hampshire	43.8	17.3	.5	.7	.7	11.9	59.5	23.4	18.3	45.0	8.0	9.9	2.9	66.7	8.1	10.6
New Jersey	636.3	15.0	.4	.7	.8	4.2	73.3	31.5	20.6	42.9	6.5	31.6	1.1	79.8	4.8	9.9
New Mexico	90.6	18.9	—	.3	.7	3.8	70.7	25.4	5.0	41.7	7.0	9.4	1.0	66.8	5.9	15.2
New York	2,145.1	17.1	1.0	3.7	1.5	1.6	60.2	25.7	21.3	46.1	15.6	38.7	8.9	62.5	8.5	12.4
North Carolina	353.8	19.2	.2	3.5	.7	3.6	71.4	25.9	11.6	37.7	8.5	22.0	.9	67.2	7.6	21.3
North Dakota	31.1	25.0	.8	9.8	.2	8.9	75.1	32.6	21.4	25.1	3.4	10.0	.4	64.8	4.2	15.7
Ohio	878.3	17.3	.2	3.6	.7	3.1	68.8	29.4	23.0	55.0	10.2	9.5	.7	69.7	2.5	8.6
Oklahoma	242.7	19.4	.2	—	.7	9.4	60.2	11.1	3.8	5.0	—	20.3	.1	43.1	1.4	16.9
Oregon	165.7	12.0	.2	.8	1.5	7.5	77.7	16.4	5.7	31.7	—	—	.3	61.7	6.1	28.6
Pennsylvania	1,098.2	11.6	.4	3.2	.7	1.3	43.4	21.4	8.7	41.1	10.8	16.2	.7	53.7	6.9	3.3
Puerto Rico	1,437.7	3.8	—	—	—	—	—	—	—	99.9	—	—	—	—	—	—
Rhode Island	123.9	15.3	—	.9	.7	5.4	63.6	25.8	19.1	41.7	—	16.2	1.1	67.8	11.8	21.4
South Carolina	250.1	25.2	2.9	1.5	1.0	4.7	72.8	17.6	9.0	40.2	—	6.6	.7	67.4	8.7	4.8
South Dakota	35.7	21.7	.5	1.6	2.3	14.9	75.0	14.8	9.2	37.7	7.1	9.3	.3	55.9	5.8	13.7
Tennessee	363.0	28.9	.7	1.3	.7	6.6	67.9	14.4	4.4	30.7	10.9	23.0	1.1	74.8	4.4	4.6
Texas	676.3	25.2	—	1.2	2.0	11.4	81.9	8.5	21.4	33.6	—	31.4	.3	78.9	6.7	15.0
Utah	59.6	15.0	.2	1.5	2.1	6.7	76.9	29.3	12.5	38.4	3.8	17.5	.4	64.9	8.9	13.9
Vermont	54.2	12.0	.3	.3	.8	5.1	71.7	22.8	27.0	44.7	7.9	5.6	3.6	71.2	8.1	8.3
Virgin Islands	15.8	10.0	—	—	—	—	1.5	3.5	—	87.9	—	.4	.1	72.5	3.0	11.7
Virginia	319.0	19.8	.2	.6	1.4	5.4	77.6	17.5	17.7	45.3	11.3	10.4	.8	70.6	12.4	6.1
Washington	253.1	18.8	.2	8.1	1.2	.5	80.4	17.8	17.6	32.2	1.9	31.1	1.0	69.1	5.8	13.1
West Virginia	178.3	19.2	—	—	.1	4.1	74.5	12.4	8.6	38.7	5.9	10.2	.3	63.1	6.3	6.9
Wisconsin	459.8	11.3	.2	8.9	.5	5.8	47.4	34.7	24.2	36.2	45.3	3.9	1.2	66.4	10.0	26.1
Wyoming	12.2	19.2	—	1.9	—	10.3	80.2	16.2	14.8	40.0	—	8.7	.3	—	4.9	3.5

SOURCE: Health Care Financing Administration, Office of the Acutary: Annual Medicaid statistics, unpublished data.

Table 4.11

Percent distribution of Medicaid recipients and payments, by age, sex, race or ethnic origin, and type of service: Fiscal year 1982

Type of service	Total recipients in thousands	Age				Sex		Race or ethnic origin				
		Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent distribution of recipients										
All services	21,603.2	19.9	30.5	31.3	18.3	35.7	64.3	54.3	38.8	.7	1.0	5.2
Inpatient hospital	3,602.3	12.4	18.2	40.5	28.9	29.1	70.9	56.3	37.3	.8	.7	4.9
Skilled nursing facility	559.2	.8	.7	12.8	85.7	28.3	71.7	87.6	11.0	.2	.6	.6
Intermediate care facility	913.4	.4	.5	13.6	85.5	28.9	71.1	86.7	11.6	.3	.2	1.1
Physicians'	13,893.7	20.6	27.9	32.6	18.9	34.4	65.6	53.4	39.3	.6	1.0	5.7
Dental	4,868.4	14.0	49.8	29.4	6.8	37.4	62.6	52.8	39.3	.8	1.5	5.5
Other practitioners'	3,223.2	5.3	29.2	37.1	28.4	30.4	69.6	57.0	35.5	.8	.6	6.1
Outpatient hospital	9,852.5	21.7	28.5	35.9	13.9	35.3	64.7	51.7	42.0	.6	.7	5.0
Clinic	1,701.9	22.4	31.8	38.1	7.7	35.9	64.1	49.1	43.0	.9	1.3	5.5
Laboratory or radiological	3,813.9	10.4	23.4	43.9	22.3	25.0	75.0	47.8	41.8	.4	1.0	9.0
Home health	377.3	8.8	6.0	37.8	47.4	27.7	72.3	65.0	30.6	.4	2.0	2.0
Prescribed drugs	13,546.7	18.9	24.5	34.2	22.4	32.9	67.1	54.6	38.2	.6	1.0	5.6
Family planning	1,506.0	.4	35.5	63.2	.8	2.2	97.8	44.8	49.7	.4	.5	4.6
Other	2,427.7	7.6	16.9	32.8	42.8	33.3	66.7	58.3	36.4	.9	.8	3.7

See footnotes at end of table.

Table 4.11—Continued

Percent distribution of Medicaid recipients and payments, by age, sex, race or ethnic origin, and type of service: Fiscal year 1982

Type of service	Payments in millions	Age				Sex		Race or ethnic origin				
		Under 6 years	6-20 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
		Percent distribution of payments										
All services	$29,399.5	6.9	13.1	41.1	39.1	33.4	66.6	69.4	26.5	.6	.7	2.9
Inpatient hospital	8,643.8	13.3	16.7	55.1	14.9	33.5	66.5	40.0	54.5	.7	.7	4.0
Skilled nursing facility	4,426.7	.8	1.0	14.9	83.3	25.2	74.8	88.1	10.3	.2	1.0	.5
Intermediate care facility	8,446.1	.4	.4	14.9	84.2	27.2	72.8	85.9	12.6	.2	.5	.9
Physicians'	2,085.5	14.2	21.0	50.9	14.0	29.8	70.2	54.7	37.2	.8	1.2	6.1
Dental	492.1	9.4	45.1	36.4	9.2	35.3	64.7	54.1	36.9	.8	2.2	6.0
Other practitioners'	226.1	4.3	26.7	48.0	21.2	33.1	66.9	64.4	29.3	1.0	.7	4.6
Outpatient hospital	1,437.7	17.1	24.3	49.0	9.8	33.5	66.5	48.1	45.8	.6	.7	4.8
Clinic	400.1	10.9	24.3	55.0	9.8	37.4	62.6	51.3	43.3	.7	.7	4.1
Laboratory or radiological	160.5	6.3	19.3	59.3	15.0	24.0	76.0	47.0	41.9	.6	.9	9.6
Home health	495.5	4.0	3.9	43.9	48.2	26.2	73.8	61.3	36.0	.3	.7	1.7
Prescribed drugs	1,598.9	5.2	7.3	40.2	47.3	27.2	72.8	66.4	28.9	.3	.5	3.8
Family planning	133.2	.2	24.4	75.0	.5	1.4	98.6	36.9	57.1	.4	.7	4.9
Other	853.0	3.9	9.4	57.7	28.8	43.6	56.3	65.0	29.7	1.0	.4	3.9

SOURCE: Health Care Financing Administration, Office of the Acutary: Annual Medicaid statistics, unpublished data.

Table 4.12

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	General hospital			SNF[1]		ICF[2] (other than for mentally retarded)		ICF-MR[3]		Physicians'			Number of drug prescriptions
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care	All visits	Rural health visits	Home health visits	
1981													
All jurisdictions	3,403,822	2,572,042	26,500,288	547,131	108,909,950	665,713	172,011,079	138,418	39,502,575	62,190,865	166,705	3,448,757	176,215,001
Alabama	59,123	44,254	327,363	6,971	1,130,983	16,283	4,294,623	633	203,717	684,123	4,098	79,063	3,171,150
Alaska	—	—	—	—	—	—	—	—	—	—	—	—	—
Arkansas	40,666	28,007	242,830	6,667	1,402,431	16,387	4,245,560	1,511	424,233	721,433	—	3,604	1,478,304
California	507,860	360,720	3,264,460	125,760	23,316,060	7,000	1,193,860	3,420	945,180	3,076,800	1,740	83,740	23,437,520
Colorado	38,909	16,651	166,553	5,418	1,162,061	10,528	3,309,524	1,694	55,230	584,015	2,411	21,661	1,321,757
Connecticut	51,638	35,689	317,384	24,610	5,125,061	82	22,559	4,627	948,826	960,532	—	—	2,305,876
Delaware	7,709	6,314	36,711	111	17,392	1,722	434,040	462	160,941	237,412	—	—	292,524
District of Columbia	52,117	20,360	575,965	618	37,015	1,620	307,145	409	89,239	712,813	—	50,165	636,031
Florida	101,620	72,610	662,517	14,180	2,444,853	21,965	5,217,188	1,610	515,617	450,706	—	49,499	6,103,189
Georgia	91,502	61,222	577,266	15,167	4,460,530	19,969	7,584,212	1,767	599,476	1,083,586	999	54,572	6,817,227
Hawaii	13,546	9,779	74,307	1,532	314,471	1,711	435,424	433	136,445	450,178	14,481	7,780	690,612
Idaho	7,028	4,925	27,553	1,780	335,005	2,442	609,533	514	141,979	175,557	822	5,404	321,469
Illinois	242,414	169,316	1,851,144	25,681	4,894,899	52,970	12,813,467	12,146	2,366,766	3,075,754	—	24,853	16,932,785
Indiana	76,834	51,861	415,937	8,284	1,444,810	2,049	628,418	25,391	7,024,680	348,880	—	—	4,769,886
Iowa	37,088	25,733	185,702	446	34,949	20,330	5,758,560	1,735	576,182	734,506	2,000	55,817	1,628,847
Kansas	—	—	—	—	—	—	—	—	—	—	—	—	—
Kentucky	84,250	57,967	440,182	6,608	845,942	16,698	3,839,472	1,380	466,130	2,034,360	—	122,838	3,041,455
Louisiana	56,476	44,924	312,487	839	144,371	29,708	7,359,846	4,614	1,358,547	2,312,612	—	23,522	4,665,938
Maine	23,107	17,611	198,502	519	51,584	8,573	2,437,835	665	228,621	362,607	—	—	1,066,938
Maryland	50,304	39,198	362,448	—	—	16,655	4,501,649	—	—	791,018	—	53,260	2,234,223
Massachusetts	—	186,191	3,650,000	22,180	5,948,000	22,281	6,352,412	2,995	933,020	3,077,000	1,632	—	5,987,900
Michigan	—	—	—	—	—	—	—	—	—	—	—	—	—
Minnesota	76,478	53,012	629,379	26,099	5,837,218	22,344	4,482,839	6,730	2,192,285	2,157,303	—	48,105	3,384,081
Mississippi	61,911	44,379	285,048	7,813	1,912,151	7,644	1,935,764	1,107	325,123	964,815	20,611	26,629	3,458,484
Missouri	72,038	51,622	515,665	1,658	132,346	20,911	5,377,554	2,255	553,763	2,510,956	—	32,920	4,264,962
Montana	11,285	7,808	62,099	460	74,305	5,195	1,284,403	255	76,033	323,364	—	—	568,061
Nebraska	15,211	10,600	85,581	1,063	183,054	9,351	2,574,515	915	311,752	642,021	2	40,558	985,407
Nevada	6,970	4,937	50,553	462	29,902	2,478	593,923	195	59,251	176,381	84	4,004	218,187
New Hampshire	7,611	5,107	50,313	314	27,192	5,012	1,409,993	325	109,095	256,886	416	35,118	495,140
New Jersey	114,082	76,918	836,272	3,967	472,670	24,741	6,759,031	5,432	1,771,192	3,180,668	—	328,787	6,563,814
New Mexico	20,303	14,440	87,644	178	27,594	3,503	789,533	570	155,997	346,395	3,004	7,865	624,846
New York	316,866	211,167	2,847,904	61,156	13,602,834	22,926	4,862,291	2,250	721,354	8,576,425	—	1,452,691	12,234,506
North Carolina	75,201	55,773	586,441	13,022	2,000,151	13,072	3,431,822	2,268	706,417	1,501,447	33,006	21,450	4,067,645
North Dakota	11,703	6,451	57,583	2,978	662,246	2,230	583,577	—	—	99,911	—	—	399,423
Ohio	157,492	116,606	1,004,131	28,993	7,295,712	25,823	7,093,156	5,196	1,599,965	2,240,873	13,591	62,267	7,600,955
Oklahoma	94,757	57,539	432,932	—	—	23,556	6,946,509	1,880	693,850	790,423	—	374	1,097,022
Oregon	22,082	16,761	91,162	943	83,580	11,058	2,796,548	2,099	725,402	1,294,454	—	—	2,714,110
Pennsylvania	191,304	157,327	1,153,473	41,547	5,655,881	19,263	2,787,506	11,294	2,275,023	2,886,994	13,234	152,691	9,381,024
Puerto Rico	59,840	54,841	282,164	—	—	—	—	—	—	—	—	—	—

See footnotes at end of table.

Table 4.12—Continued

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	General hospital			SNF[1]		ICF[2] (other than for mentally retarded)		ICF-MR[3]		Physicians'			
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care	All visits	Rural health visits	Home health visits	Number of drug prescriptions
1981													
Rhode Island	13,896	—	881,782	1,192	56,575	6,874	2,105,320	861	314,265	347,336	2,987	23,036	1,146,738
South Carolina	57,541	39,122	202,149	4,318	701,993	10,472	2,185,563	2,514	629,788	1,118,675	770	49,391	2,390,622
South Dakota	9,451	6,317	75,973	989	211,614	5,139	1,600,275	801	297,594	224,979	6,248	1,804	246,152
Tennessee	70,460	52,202	306,766	4,623	642,683	23,625	5,929,404	2,557	911,738	816,634	3,929	51,070	5,949,266
Texas	140,934	95,676	892,182	9,329	1,563,394	80,062	23,255,134	12,876	4,316,709	4,343,501	6,961	31,277	6,856,519
Utah	11,730	11,730	73,476	1,388	214,811	3,996	1,066,220	1,262	429,426	242,047	4,963	12,492	629,266
Vermont	9,624	6,789	54,823	286	24,583	2,963	781,066	411	135,817	312,543	3,155	67,224	517,306
Virgin Islands	1,203	1,004	7,529	—	—	—	—	—	—	823	—	137	21,120
Virginia	63,226	46,038	402,302	1,716	244,164	16,712	4,437,076	4,729	1,485,621	1,347,052	—	67,143	3,555,861
Washington	63,022	38,342	233,855	21,018	5,343,048	1,459	396,518	759	209,505	1,370,371	874	80,465	2,408,422
West Virginia	40,192	29,724	219,297	274	13,350	—	—	—	—	2,195,976	24,555	9,810	1,285,131
Wisconsin	65,218	46,478	366,817	43,974	8,789,482	26,331	5,200,212	2,871	820,781	767,720	132	205,671	6,247,337
Wyoming	—	—	—	—	—	—	—	—	—	—	—	—	—
1982													
All jurisdictions	3,230,302	2,655,991	25,460,168	510,758	112,070,880	686,763	180,844,412	126,539	37,071,578	77,013,581	146,500	5,565,304	175,830,755
Alabama	56,924	42,514	325,826	147	46,856	18,275	4,719,737	1,376	491,421	679,543	4,369	93,401	3,213,290
Alaska	—	—	—	—	—	—	—	—	—	—	—	—	—
Arkansas	30,354	21,931	171,508	5,962	1,242,050	16,623	4,348,651	1,444	477,497	615,734	—	5,737	980,234
California	488,760	348,620	2,956,280	118,560	23,380,580	6,420	1,111,940	3,240	914,840	9,997,760	580	104,980	24,060,800
Colorado	43,027	16,984	166,907	5,240	1,151,856	10,070	2,681,386	1,989	682,345	415,548	2,411	110,184	1,429,286
Connecticut	39,519	25,254	239,432	16,280	4,366,910	3,244	854,781	1,317	357,013	374,502	—	510,550	1,998,176
Delaware	7,376	5,863	34,338	88	6,380	1,656	429,413	464	152,331	231,512	—	—	283,755
District of Columbia	21,001	15,669	173,194	648	61,359	2,069	449,005	396	50,914	1,336,675	—	512,402	10,257,084
Florida	98,655	70,270	640,217	13,487	2,103,183	22,945	5,434,996	4,538	693,358	456,091	—	44,317	5,785,531
Georgia	87,251	60,008	517,107	13,977	3,601,040	19,076	6,039,902	1,792	658,234	1,000,001	6,187	187,337	5,468,558
Hawaii	14,152	10,394	15,443	1,492	307,666	1,792	434,023	431	133,640	440,750	3,846	7,445	692,750
Idaho	6,521	4,659	26,016	1,555	276,184	2,438	629,930	517	168,402	170,064	373	5,415	301,915
Illinois	245,593	172,821	1,672,037	21,466	5,499,595	47,359	12,500,196	8,034	2,343,823	4,764,195	—	64,178	12,888,904
Indiana	—	—	—	—	—	—	—	—	—	—	—	—	—
Iowa	33,934	23,410	183,176	353	37,632	19,803	5,719,290	1,720	591,508	629,980	1,371	53,737	1,583,713
Kansas	30,273	20,499	180,861	982	95,070	15,614	4,749,943	2,213	737,020	426,302	42	19,387	1,444,926
Kentucky	—	—	—	5,504	623,696	15,625	3,868,023	1,577	430,750	1,665,343	1,065	112,258	2,324,103
Louisiana	117,564	82,972	450,139	840	153,437	27,957	7,821,022	4,689	1,603,706	3,153,558	—	34,489	4,800,990
Maine	35,143	24,949	107,728	897	66,128	9,055	2,460,051	661	229,669	421,661	16,828	18,243	1,068,503
Maryland	49,349	38,555	300,950	—	—	16,475	4,507,215	2,007	639,076	919,765	—	—	2,271,449
Massachusetts	—	166,839	3,270,483	20,523	5,493,176	20,069	5,713,890	2,657	827,735	2,931,913	2,512	—	6,333,077
Michigan	183,669	146,058	1,330,869	19,689	3,243,003	36,437	9,049,718	4,390	1,404,330	9,360,265	—	90,991	9,229,782
Minnesota	80,002	53,969	650,105	26,692	6,188,523	21,391	4,340,914	7,401	3,443,094	2,193,985	—	52,656	3,253,192
Mississippi	54,857	40,825	251,353	7,493	1,782,428	8,734	2,262,056	1,321	428,815	809,171	22,422	21,183	3,071,337

See footnotes at end of table.

Table 4.12—Continued

Selected measures of use of services by Medicaid recipients, by jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	General hospital			SNF[1]		ICF[2] (other than for mentally retarded)		ICF-MR[3]		Physicians'			
	Discharges	Recipients discharged	Days of care	Recipients	Days of care	Recipients	Days of care	Recipients	Days of care	All visits	Rural health visits	Home health visits	Number of drug prescriptions
1982													
Missouri	71,831	48,696	429,611	1,854	93,160	21,695	5,728,888	2,402	549,896	2,196,337	—	27,370	3,035,972
Montana	10,592	6,790	60,013	276	49,285	4,614	1,255,152	320	96,013	335,204	—	—	418,684
Nebraska	15,701	10,993	83,867	1,090	185,382	9,185	2,512,502	1,027	320,355	572,085	—	42,263	963,254
Nevada	6,440	4,351	47,823	369	33,207	2,441	623,258	208	61,554	137,416	84	4,342	213,857
New Hampshire	7,029	5,278	33,481	300	21,099	5,195	1,520,709	317	105,907	212,850	599	17,981	381,787
New Jersey	111,293	76,907	825,092	4,362	496,333	26,736	6,952,987	5,155	1,578,166	2,706,144	—	339,913	6,305,570
New Mexico	18,312	13,394	59,720	276	36,222	3,460	765,796	594	178,294	336,957	7,058	25,704	622,283
New York	240,656	365,030	3,551,873	71,082	20,587,796	24,471	6,907,917	14,793	1,302,514	8,326,656	—	2,403,925	16,881,129
North Carolina	80,673	61,879	595,065	12,472	2,061,499	12,655	3,324,391	2,594	846,950	1,361,999	12,353	23,534	2,924,171
North Dakota	10,819	5,776	48,643	3,042	696,994	2,752	635,868	47	14,768	82,978	—	—	364,726
Ohio	169,587	123,629	1,085,010	29,653	7,934,950	26,552	7,649,560	6,247	1,987,991	2,350,493	11,882	88,722	8,010,515
Oklahoma	78,281	47,190	363,820	—	—	22,838	6,387,042	1,787	573,967	743,190	—	751	1,008,472
Oregon	35,596	15,753	144,546	1,330	96,417	12,491	2,830,914	2,530	716,771	1,114,416	—	—	2,723,254
Pennsylvania	141,268	103,957	930,435	35,441	5,483,639	14,027	4,093,740	7,316	2,595,537	2,587,152	—	—	10,422,832
Puerto Rico	74,312	72,624	356,332	—	—	—	—	—	—	—	—	—	—
Rhode Island	12,468	—	900,558	1,663	73,172	6,419	2,148,383	1,043	314,791	318,039	2,039	25,164	1,038,029
South Carolina	43,101	33,530	209,872	3,682	731,248	11,677	2,710,609	2,396	671,201	865,694	656	39,289	1,778,565
South Dakota	9,819	6,512	55,535	685	129,424	5,307	1,545,546	815	268,560	247,666	6,464	2,793	285,446
Tennessee	—	—	—	—	—	—	—	—	—	—	—	—	—
Texas	128,806	89,905	776,228	7,635	1,120,262	74,451	19,304,423	13,193	4,350,897	5,363,929	1,270	30,534	6,315,736
Utah	11,041	11,041	72,235	894	132,013	3,914	1,033,399	1,254	429,084	—	—	—	—
Vermont	9,475	6,498	59,724	181	17,402	2,791	704,933	413	162,919	347,066	8,297	83,957	466,564
Virgin Islands	1,262	1,089	7,040	—	—	—	—	—	—	658	—	295	29,423
Virginia	60,399	43,933	375,723	1,641	253,700	17,272	4,599,507	4,636	1,455,259	1,134,000	—	76,471	3,515,863
Washington	47,401	27,982	182,465	20,217	5,318,214	1,327	361,607	720	200,924	1,087,092	371	67,655	2,164,538
West Virginia	37,426	27,385	174,780	—	—	7,366	1,397,472	136	10,064	824,657	33,257	14,024	1,055,543
Wisconsin	70,243	50,967	353,359	30,505	6,743,035	22,749	5,397,468	2,422	819,675	703,799	164	200,182	4,487,290
Wyoming	2,547	1,839	13,349	233	49,675	1,251	326,259	—	—	62,786	—	1,545	—

[1] Skilled nursing facility.
[2] Intermediate care facility.
[3] Intermediate care facility for the mentally retarded.

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Expenditures

In this section, the distribution of Medicaid vendor payments is described by program, basis of eligibility, type of service, and age, race or ethnicity, and sex of recipient. The distribution of vendor payments is shown in Table 4.13 by aid category and maintenance assistance status—cash assistance or medical assistance only. Cash assistance recipients accounted for 54.1 percent of total vendor payments; medical assistance recipients for 45.9 percent. Except for the aged category, cash assistance recipients accounted for the larger share of vendor payments in each eligibility group.

Medicaid expenditures for FY 1981 and 1982, by rank of total payments for each jurisdiction and basis of eligibility, are displayed in Table 4.14. In FY 1982, the aged group accounted for the largest share of total vendor payments (36.5 percent), even though this group represented only 15.0 percent of all recipients (see Table 4.5). The disabled also accounted for a disproportionate share of total vendor payments (34.8 percent of total vendor payments as opposed to 13.0 percent of total recipients). In contrast, AFDC recipients, while representing 69.1 percent of all recipients, accounted for only 25.7 percent of total vendor payments.

New York and California accounted for 30.8 percent of all vendor payments in FY 1982, and six States accounted for nearly 50 percent of the total. (These six States also accounted for 46.4 percent of total recipients.)

In Table 4.15, Medicaid programs are ranked by number of recipients and total vendor payments. (See Tables 4.5 and 4.14, respectively.) The two rankings are closely related. The most noticeable exception is Puerto Rico, which ranks third in number of recipients, but only 39th in terms of total vendor payments. This inconsistency reflects the congressionally mandated expenditure "cap" placed on Puerto Rico in 1972.

The distribution of vendor payments in each program is shown in Table 4.16 by age, sex, and race or ethnicity of those receiving services. Medicaid vendor payments varied widely across different age groups. Greater consistency existed with respect to sex, with females accounting for the larger share of total vendor payments in all jurisdictions.

The distribution of vendor payments across service categories is shown for each Medicaid program in FY 1981 and 1982 in Table 4.17. Among programs reporting for FY 1982, 29.4 percent of all vendor payments went for inpatient hospital services (including general and mental hospitals), followed closely by ICF's (28.7 percent) and SNF's (15.1 percent).

In Table 4.18, States are ranked by the ratio of Medicaid recipients to persons living at or below the U.S. poverty level (as defined by the Census Bureau). (It should be noted that the ratio of Medicaid recipients living at or below the poverty level in Table 4.18 includes persons receiving State-only services.) Average expenditures per Medicaid recipient and average per capita personal income are also reported for each State. The ratio of Medicaid recipients to persons living at or below the poverty level ranged from a low of 17 in South Dakota to a high of 104 in Hawaii. Average expenditures per Medicaid recipient ranged from a low of $679 in West Virginia to a high of $2,604 in New York.

Table 4.13

Amount and percent distribution of Medicaid payments, by maintenance assistance status and basis of eligibility: Fiscal year 1982

Basis of eligibility	Total payments in millions	Maintenance assistance status	
		Cash assistance	Medical assistance only
		Percent distribution	
Total	$29,399.5	54.1	45.9
Age 65 or over	10,739.1	25.2	74.8
Blind	172.5	69.9	30.1
Disabled	10,232.8	63.2	36.8
Dependent children under age 21	3,473.5	85.7	14.3
Adults in families with dependent children	4,093.1	87.7	12.3
Other Title XIX	688.5	NA	100.0

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Financing

Under Medicaid, service providers (physicians, pharmacists, hospitals, etc.) may be reimbursed from several different sources, including:

- The Federal Government, through Federal matching assistance payments.
- The Federal Government, through Medicare supplementary medical insurance "buy-in" agreements.
- State governments.
- Local governments (in some cases).
- Third parties who are otherwise liable for care provided to Medicaid eligibles.
- Medicaid recipients themselves.

This section presents data on each source of funds except private third parties and Medicaid recipients themselves.

Federal and State financing

The Federal share of State medical vendor payments is determined by a statutory formula based on State per capita income, where

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times .45$$

and where the Federal share equals 1.00 minus the State share. By design, the formula sets higher rates of Federal matching (up to a statutory maximum of 83 percent) for States with relatively low per capita incomes and lower rates (to a minimum of 50 percent) for States with relatively high per capita incomes.

Table 4.14

Payments for Medicaid recipients, by jurisdiction, by rank of jurisdiction, and percent distribution, by basis of eligibility: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Payments in millions	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	AFDC[2]	Other Title XIX
1981				Percent distribution				
All jurisdictions	$27,204.3	100.0	100.0	36.5	.6	34.1	26.7	2.0
New York	5,252.5	19.3	19.3	38.4	.2	39.6	19.6	2.1
California	3,402.7	12.5	31.8	26.4	1.1	33.5	34.2	4.7
Illinois	1,322.2	4.9	36.7	19.6	.2	40.3	39.5	.4
Michigan	1,260.3	4.6	41.3	28.1	.3	32.8	38.5	.3
Pennsylvania	1,255.0	4.6	45.9	36.2	.4	35.3	26.4	1.7
Texas	1,144.5	4.2	50.1	49.1	.6	32.8	17.5	NA
Massachusetts	1,120.3	4.1	54.2	46.8	1.4	28.7	20.8	2.4
Ohio	1,005.4	3.7	57.9	35.4	.5	30.1	34.1	—
Wisconsin	834.4	3.1	61.0	40.8	.6	33.4	24.3	1.0
New Jersey	791.6	2.9	63.9	34.9	.3	27.0	32.9	4.9
Minnesota	679.9	2.5	66.4	47.1	.4	32.0	16.8	3.7
Georgia	533.5	2.0	68.4	36.0	.8	40.2	22.8	.2
Florida	489.0	1.8	70.2	42.3	.6	31.6	25.5	—
North Carolina	477.9	1.8	72.0	38.5	1.2	32.7	24.1	3.4
Louisiana	434.3	1.6	73.6	41.6	.6	37.2	20.5	—
Virginia	429.0	1.6	75.2	41.1	.5	32.0	25.2	1.1
Washington	424.1	1.6	76.8	34.6	.2	36.0	29.2	—
Tennessee	423.5	1.6	78.4	38.4	.9	37.3	23.5	—
Indiana	419.5	1.5	79.9	40.1	.7	38.8	20.5	—
Connecticut	379.8	1.4	81.3	47.1	.2	27.4	25.2	—
Missouri	374.5	1.4	82.7	41.9	1.1	27.9	28.7	.4
Kentucky	361.1	1.3	84.0	31.8	.7	34.0	31.1	2.4
Oklahoma	353.1	1.3	85.3	41.8	.2	29.8	28.1	.1
Maryland	348.5	1.3	86.6	39.7	.2	20.5	39.6	—
Alabama	282.8	1.0	87.6	44.6	.6	30.4	23.8	.6
Iowa	273.7	1.0	88.6	37.5	.6	30.3	29.2	2.4
Arkansas	273.6	1.0	89.6	40.5	1.0	38.6	15.8	4.1
South Carolina	258.9	1.0	90.6	39.8	.8	35.1	24.3	.1
Mississippi	236.4	.9	91.5	45.1	.7	29.3	24.7	.1
Kansas	218.5	.8	92.3	34.9	.3	32.8	27.2	4.7
Colorado	215.7	.8	93.1	40.2	.9	33.0	23.1	2.9
Oregon	195.4	.7	93.8	32.8	2.4	31.3	25.1	8.4
Rhode Island	186.6	.7	94.5	48.1	.4	36.0	15.1	.4
District of Columbia	160.1	.6	95.1	19.5	.1	33.8	46.6	—
Maine	148.9	.5	95.6	47.9	.2	24.3	26.9	.8
Nebraska	125.5	.5	96.1	41.6	.7	33.5	21.2	3.0
West Virginia	124.7	.5	96.6	34.0	.4	29.7	35.9	—
Hawaii	112.0	.4	97.0	37.5	.2	22.6	39.3	.4
Utah	99.0	.4	97.4	29.8	.3	37.2	26.4	6.4
Puerto Rico	97.8	.4	97.8	—	.1	3.9	52.1	44.0
New Mexico	88.9	.3	98.1	25.8	1.4	39.9	32.1	.9
New Hampshire	80.9	.3	98.4	59.9	1.8	21.3	16.8	.2
Montana	73.0	.3	98.7	42.6	1.0	33.4	21.4	1.7
Vermont	71.1	.3	99.0	37.6	.2	35.4	25.5	1.3
South Dakota	68.1	.3	99.3	48.9	.3	34.2	16.0	.6
North Dakota	62.1	.2	99.5	57.8	.1	16.4	21.6	4.1
Nevada	61.5	.2	99.7	36.4	1.6	39.3	21.1	1.7
Idaho	57.6	.2	99.9	37.0	.2	40.2	22.0	.6
Delaware	51.8	.2	100.1	34.8	.1	30.6	32.7	1.7
Alaska	44.0	.2	100.3	41.2	.7	39.3	18.6	.2
Wyoming	16.9	.1	100.4	53.2	.7	23.3	22.5	.3
Virgin Islands	1.9	z	100.4	18.8	—	6.8	69.0	5.3

See footnotes at end of table.

Table 4.14—Continued

Payments for Medicaid recipients, by jurisdiction, by rank of jurisdiction, and percent distribution, by basis of eligibility: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Payments in millions	Percent of total	Cumulative percent of total	Basis of eligibility[1]				
				Age 65 or over	Blind	Disabled	AFDC[2]	Other Title XIX
1982			Percent distribution					
All jurisdictions	$29,399.5	100.0	100.0	36.5	.6	34.8	25.7	2.3
New York	5,585.9	19.0	19.0	38.4	.2	39.6	19.6	2.1
California	3,536.5	11.8	30.8	24.6	1.1	34.2	35.4	4.7
Pennsylvania	1,651.8	5.5	36.3	38.2	.6	35.6	24.3	1.4
Illinois	1,344.4	4.5	40.8	20.4	.2	40.9	38.1	.3
Michigan	1,292.6	4.3	45.1	25.4	.4	34.6	38.8	.8
Ohio	1,227.1	4.1	49.2	33.8	.4	31.7	34.1	—
Massachusetts	1,207.5	4.0	53.2	47.1	1.6	28.7	20.3	2.3
Texas	1,157.5	3.9	57.1	45.8	.7	36.2	17.2	.1
New Jersey	874.7	2.9	60.0	35.8	.3	28.7	30.7	4.5
Wisconsin	820.9	2.7	62.7	39.0	.5	32.0	24.1	4.3
Minnesota	795.5	2.7	65.4	45.0	.4	35.4	15.6	3.7
Louisiana	577.8	1.9	67.3	39.8	.6	39.3	19.6	.8
Georgia	569.6	1.9	69.2	34.5	.8	40.8	23.7	.2
Florida	553.4	1.9	71.1	41.4	.7	34.2	23.8	—
Indiana	494.8	1.7	72.8	40.1	.7	38.8	20.5	—
North Carolina	482.8	1.6	74.4	40.2	1.2	33.4	21.8	3.4
Virginia	472.6	1.6	76.0	43.2	.6	32.1	23.2	1.0
Tennessee	464.3	1.6	77.6	38.4	.9	37.3	23.5	—
Washington	425.9	1.4	79.0	36.7	.2	40.1	23.0	—
Maryland	417.7	1.4	80.4	36.3	.2	28.2	35.4	—
Missouri	384.4	1.3	81.7	44.4	.9	28.6	25.1	1.0
Oklahoma	361.6	1.2	82.9	44.1	.2	28.3	27.4	.1
Connecticut	358.3	1.2	84.1	51.3	.2	25.4	19.3	3.8
Kentucky	341.3	1.1	85.2	34.6	.7	34.9	28.6	1.1
Alabama	338.1	1.1	86.3	40.5	.7	35.0	23.4	.5
Iowa	287.3	1.0	87.3	36.5	.5	32.5	26.3	4.2
South Carolina	278.9	.9	88.2	39.7	.7	36.9	22.7	.1
Arkansas	266.6	.9	89,1	42.6	1.1	40.1	13.4	2.8
Mississippi	262.9	.9	90.0	44.6	.7	31.8	22.8	.1
Colorado	244.0	.8	90.8	39.5	1.0	34.2	22.1	3.2
Kansas	233.1	.8	91.6	34.0	.3	33.3	29.0	3.5
Rhode Island	201.0	.7	92.3	48.1	.4	36.0	15.1	.4
Oregon	187.9	.6	92.9	34.6	2.6	30.3	28.0	4.5
District of Columbia	178.9	.6	93.5	20.3	.1	31.9	47.1	.5
Maine	177.8	.6	94.1	45.4	.2	28.3	25.2	.9
Nebraska	134.9	.5	94.6	41.8	.6	33.9	20.9	2.8
Hawaii	125.0	.4	95.0	40.4	.3	22.6	36.3	.4
West Virginia	121.0	.4	95.4	38.8	.3	26.9	34.1	—
Puerto Rico	116.0	.4	95.8	—	.1	3.9	52.6	43.4
Utah	97.9	.3	96.1	26.3	.2	40.0	25.4	8.2
New Mexico	97.5	.3	96.4	25.8	1.5	41.4	30.2	1.1
New Hampshire	86.7	.3	96.7	63.0	1.7	20.7	14.5	.1
Montana	86.5	.3	97.0	42.6	1.0	33.4	21.4	1.7
Vermont	78.4	.3	97.3	37.7	.2	39.5	21.6	1.1
South Dakota	76.9	.3	97.6	44.1	.4	39.4	15.2	1.0
North Dakota	65.9	.2	97.8	60.0	.2	16.8	19.2	3.8
Nevada	65.4	.2	98.0	35.4	1.7	42.1	19.2	1.5
Idaho	63.5	.2	98.2	37.1	.2	41.2	20.9	.6
Delaware	55.8	.2	98.4	35.0	.1	31.4	31.9	1.7
Alaska	50.4	.2	98.6	41.2	.7	39.3	18.6	.2
Wyoming	18.9	.1	98.7	54.6	.4	16.8	28.1	—
Virgin Islands	3.2	z	100.0	18.8	.1	6.8	68.9	5.4

[1] The sum of percentages by basis of eligibility may exceed 100 percent because of a recipient may be counted in more than one eligibility group.
[2] Aid to Families With Dependent Children.

SOURCE: Health Care Financing Administration, Office of the Actuary; Annual Medicaid statistics, unpublished data.

The Federal Medicaid assistance percentages (FMAP's) in effect since the enactment of Medicaid are shown in Table 4.19. No State receives the maximum Federal match of 83 percent. For FY 1983-85, 17 States receive the minimum; Mississippi will receive the highest at 77.6 percent. These percentages apply to medical vendor payments only.

Although FMAP's are calculated for the territories, the total amount of Federal Medicaid matching funds payable to the territories is limited by statute. The following "caps" apply for FY 1984:

American Samoa	$ 750,000
Guam	1,400,000
Northern Marianas	275,000
Puerto Rico	[9] 63,400,000
Virgin Islands	5,000,000

For FY 1982, Federal matching rates for other expenditures were as follows:

- Family planning services were matched at 90 percent.
- Administrative costs were matched at 75 percent.
- Development of automated claims processing and management information systems were matched at 90 percent, and the operation of such system was matched at 75 percent.
- Costs of skilled nursing facility inspectors were matched at 75 percent.
- Costs of professional medical personnel used to administer the program were matched at 75 percent.
- State Medicaid fraud and abuse units located organizationally outside of the single State agency were matched at 90 percent.

The share of total expenditures for medical assistance borne by the States varies with the extent to which States provide medical assistance to State-only eligibles and offer services which do not qualify for Federal financial participation.

Section 2161 of OBRA-81 reduces the total Federal reimbursement each State will receive by 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984. The specified reduction for each state is computed on the total Federal Medicaid reimbursement it claimed in that year. A State can lower its annual reduction rate by 1 percentage point for each of the following three conditions: (1) operation of a qualified hospital cost review program; (2) an unemployment rate exceeding 150 percent of the national average; and (3) fraud and abuse recoveries (including third-party liability recoveries in FY 1982) equal to 1 percent of Federal payments of the State (42 CFR 433 Subpart E).

In addition to the conditions cited above, Section 2161 of OBRA-81 allows for a decrease in the designated reduction in Federal matching dollars for each State that keeps its spending levels within a "target" rate of growth. For FY 1982, the target level is set at 109 percent of each State's estimate of the Federal share of its FY 1981 spending level, or a 9-percent rate of growth. For FY 1983 and 1984, target levels are based on changes in the medical care component of the Consumer Price Index. In each year, $1 will be deducted from a State's scheduled reduction in Federal matching funds for every dollar in State spending below the target level. (For purposes of calculating target rates only, Section 137 of TEFRA removed the effect of changes in FMAP's for the States after FY 1981.)

[9] Under the Deficit Reduction Act (Public Law 98.369), Puerto Rico's cap was raised to $63.4 million for FY 1984.

Table 4.15

Medicaid jurisdictions ranked by number of recipients and payments for recipients: Fiscal year 1982

Medicaid jurisdiction	Number of recipients	Amount of payments
California	1	2
New York	2	1
Puerto Rico	3	39
Michigan	4	5
Pennsylvania	5	3
Illinois	6	4
Ohio	7	6
Texas	8	8
Massachusetts	9	7
New Jersey	10	9
Florida	11	14
Wisconsin	12	10
Georgia	13	13
Louisiana	14	12
Tennessee	15	18
North Carolina	16	16
Kentucky	17	24
Missouri	18	21
Minnesota	19	11
Maryland	20	20
Alabama	21	25
Virginia	22	17
Mississippi	23	29
Washington	24	19
South Carolina	25	27
Oklahoma	26	22
Indiana	27	15
Connecticut	28	23
Arkansas	29	28
Iowa	30	26
West Virginia	31	38
Oregon	32	33
Kansas	33	31
Colorado	34	30
Maine	35	35
Rhode Island	36	32
District of Columbia	37	34
Hawaii	38	37
New Mexico	39	41
Nebraska	40	36
Utah	41	40
Vermont	42	44
Montana	43	43
Delaware	44	49
New Hampshire	45	42
Idaho	46	48
South Dakota	47	45
North Dakota	48	46
Nevada	49	47
Alaska	50	50
Virgin Islands	51	52
Wyoming	52	51

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Table 4.16

Average Medicaid payment per recipient, by jurisdiction, and percent distribution of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1982

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin				
			Under 20 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
			Percent distribution									
All jurisdictions	$29,399.5	$1,361	19.4	39.5	41.2	33.2	66.8	69.2	25.6	.5	.7	1.0
Alabama	338.1	1,051	14.8	39.4	45.8	29.9	70.1	58.7	41.2	—	—	.1
Alaska	50.4	—	—	—	—	—	—	—	—	—	—	—
Arkansas	266.6	1,358	17.4	33.7	48.9	34.3	65.7	71.5	28.4	—	—	—
California	3,536.5	944	25.1	45.9	29.0	34.5	65.5	—	—	—	—	—
Colorado	244.0	1,699	18.3	39.2	42.5	34.8	65.2	75.2	5.8	.4	.3	18.3
Connecticut	358.3	1,813	13.2	34.2	52.5	31.2	68.8	81.6	18.4	—	—	—
Delaware	55.8	1,157	24.4	40.5	35.1	34.1	65.9	59.6	37.7	—	.4	2.3
District of Columbia	178.9	1,650	24.5	52.6	22.9	31.3	68.7	7.8	92.1	.1	—	—
Florida	553.4	1,064	17.8	35.4	46.9	29.6	70.4	67.6	31.4	—	.1	1.0
Georgia	569.6	1,301	17.9	40.7	41.4	31.3	68.7	56.3	43.7	—	—	—
Hawaii	125.0	1,225	21.8	37.6	40.6	38.0	62.0	21.8	.4	—	76.6	1.3
Idaho	63.5	1,594	23.4	39.0	37.6	36.9	63.1	94.4	.4	.3	2.2	2.8
Illinois	1,344.4	1,264	24.2	49.9	25.9	35.1	64.9	54.8	39.4	.1	.4	5.3
Indiana	494.8	—	—	—	—	—	—	—	—	—	—	—
Iowa	287.3	1,600	21.6	39.5	38.9	34.5	65.5	94.7	4.2	.2	.5	.4
Kansas	233.1	—	—	—	—	—	—	—	—	—	—	—
Kentucky	341.3	968	22.4	40.5	37.1	33.2	66.8	86.5	13.5	—	—	—
Louisiana	577.8	1,486	19.4	39.4	41.3	34.9	65.1	55.6	44.4	—	—	—
Maine	177.8	1,399	15.5	35.7	48.8	32.9	67.1	—	—	—	—	—
Maryland	417.7	1,292	21.3	35.5	43.3	28.0	72.0	56.2	43.8	—	—	—
Massachusetts	1,207.5	1,775	12.0	40.0	47.9	31.7	68.3	—	—	—	—	—
Michigan	1,292.6	—	—	—	—	—	—	—	—	—	—	—
Minnesota	795.5	2,461	14.8	36.0	49.2	36.9	63.1	93.8	2.2	1.9	1.8	.3
Mississippi	262.9	866	19.8	31.0	49.2	30.2	69.8	47.9	52.0	—	—	—
Missouri	384.4	1,137	13.4	36.3	50.3	29.7	70.3	76.5	23.5	—	—	—
Montana	86.5	1,333	13.9	35.8	50.3	34.5	65.5	91.5	.3	7.2	.2	.8

See footnotes at end of table.

Table 4.16—Continued

Average Medicaid payment per recipient, by jurisdiction, and percent distribution of payments, by age, sex, race or ethnic origin, and jurisdiction: Fiscal year 1982

Medicaid jurisdiction	Total payments in millions	Payment per recipient	Age			Sex		Race or ethnic origin				
			Under 20 years	21-64 years	65 years or over	Male	Female	White	Black	American Indian or Alaskan native	Asian or Pacific Islander	Hispanic
						Percent distribution						
Nebraska	$134.9	1,734	18.6	38.3	43.2	35.4	64.6	85.7	10.4	2.0	.5	1.5
Nevada	65.4	2,284	23.2	38.6	38.2	34.8	65.2	94.0	.5	2.1	—	3.4
New Hampshire	86.7	1,979	7.9	27.4	64.7	28.9	71.1	100.0	—	—	—	—
New Jersey	874.7	1,375	22.7	39.0	38.3	32.7	67.3	64.1	27.8	—	.1	7.9
New Mexico	97.5	1,076	22.2	49.2	28.6	34.9	65.1	92.7	3.4	3.9	—	—
New York	5,585.9	2,604	17.5	32.3	50.2	31.6	68.4	76.4	20.6	.2	.1	2.7
North Carolina	482.8	1,365	18.3	40.7	41.0	33.9	66.1	60.3	38.4	—	.1	1.2
North Dakota	65.9	2,121	12.8	26.9	60.3	34.6	65.4	89.5	.1	10.0	.2	.2
Ohio	1,227.1	1,397	21.2	43.2	35.7	31.5	68.5	75.6	23.8	—	—	.6
Oklahoma	361.6	1,490	23.1	32.3	44.6	35.8	64.2	81 4	13.0	5.0	.1	.5
Oregon	187.9	1,134	—	—	—	—	—	—	—	—	—	—
Pennsylvania	1,651.8	1,504	18.4	42.3	39.3	36.2	63.8	67.6	29.2	—	.2	2.9
Puerto Rico	116.0	99	—	45.9	54.1	41.9	58.1	—	—	—	—	100.0
Rhode Island	201.0	1,668	9.1	40.4	50.5	31.3	68.7	83.4	10.6	.1	2.5	3.4
South Carolina	278.9	1,115	18.8	37.1	44.1	29.3	70.7	52.7	47.2	—	—	—
South Dakota	76.9	2,153	18.3	35.4	46.3	37.3	62.7	86.8	.1	13.1	—	—
Tennessee	464.3	—	—	—	—	—	—	—	—	—	—	—
Texas	1,157.5	1,712	15.8	38.0	46.1	33.8	66.2	64.7	20.3	—	.2	14.7
Utah	97.9	1,644	27.0	45.9	27.1	37.7	62.3	91.5	1.2	1.6	.5	5.2
Vermont	78.4	1,446	17.4	43.8	38.8	35.3	64.7	99.0	.1	—	.9	—
Virgin Islands	3.2	198	45.1	37.6	17.3	34.9	65.1	—	—	—	—	—
Virginia	472.6	1,481	16.7	39.1	44.1	33.1	66.9	60.2	39.3	—	.3	.2
Washington	425.9	1,623	17.7	39.2	43.1	30.7	69.3	90.5	4.2	2.3	1.3	1.6
West Virginia	121.0	679	19.9	40.3	39.8	26.1	73.9	95.0	4.9	—	—	—
Wisconsin	820.9	1,781	18.5	37.8	43.8	35.0	65.0	86.2	10.6	1.3	.3	1.6
Wyoming	18.9	1,558	17.5	28.5	54.0	28.4	71.6	91.1	1.4	1.2	—	6.1

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Beginning in FY 1983, Section 133 of TEFRA requires that Federal matching funds to States with eligibility error rates greater than 3 percent be reduced by the amount of the excess erroneous expenditures. The Secretary of Health and Human Services is permitted to waive the penalty retroactively in certain limited cases based on a determination that the State made a good-faith effort to reduce its error rate to 3 percent. Several factors are considered in calculating the error rate:

- Inclusion of payments to ineligible medical vendors and overpayments to eligible medical vendors.
- Exclusion of technical errors.
- Inclusion of the smaller amount of medical assistance provided, or spend-down and resource errors, or the amount attributed to both.

Table 4.17

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Total payments in millions	Type of service					
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'
		General hospital	Mental hospital		Mentally retarded	All other	
1981		Percent distribution					
All jurisdictions	$27,204.3	26.4	3.2	14.8	11.0	16.6	7.7
Alabama	282.8	23.3	.4	8.4	6.2	32.3	11.2
Alaska	44.0	18.2	NA	8.8	21.9	34.9	7.0
Arkansas	273.6	18.1	.1	12.1	11.1	30.9	9.6
California	3,402.7	34.7	2.5	19.3	1.2	.8	15.8
Colorado	215.7	19.2	3.1	11.6	14.9	27.2	4.9
Connecticut	379.8	18.5	12.3	43.6	.1	4.9	4.5
Delaware	51.8	25.0	2.7	1.0	14.3	30.7	10.4
District of Columbia	160.1	52.2	NA	1.2	3.6	10.5	9.4
Florida	489.0	31.5	1.3	11.7	5.9	21.3	8.5
Georgia	533.5	25.7	NA	13.5	8.4	20.7	9.6
Hawaii	112.0	20.6	NA	17.7	NA	17.2	16.5
Idaho	57.6	17.5	NA	17.2	17.4	25.1	6.9
Illinois	1,322.2	35.3	.8	8.8	9.9	16.3	8.0
Indiana	419.5	23.5	12.3	NA	7.6	37.7	5.2
Iowa	273.7	20.4	.7	.5	16.4	36.2	9.7
Kansas	218.5	21.1	4.5	1.1	15.8	34.0	7.2
Kentucky	361.1	27.4	.7	7.9	8.1	24.5	12.1
Louisiana	434.3	16.1	.3	1.0	17.4	36.3	8.8
Maine	148.9	20.6	NA	1.7	6.4	45.3	7.2
Maryland	348.5	37.0	NA	NA	NA	36.5	7.5
Massachusetts	1,120.3	35.1	2.4	15.7	10.4	13.8	4.2
Michigan	1,260.3	32.6	.1	7.3	12.3	17.4	12.5
Minnesota	679.9	13.9	1.2	30.5	16.5	17.7	6.0
Mississippi	236.4	26.2	NA	19.8	5.3	18.4	10.6
Missouri	374.5	27.6	NA	1.0	10.2	33.7	5.8
Montana	73.0	20.5	.3	2.5	6.0	45.0	9.5
Nebraska	125.5	19.1	2.6	4.7	13.3	36.9	7.3
Nevada	61.5	33.7	.5	1.6	7.8	31.8	11.9
New Hampshire	80.9	15.3	3.6	1.3	7.1	55.1	4.0
New Jersey	791.6	24.0	5.2	2.1	14.2	26.4	6.8
New Mexico	88.9	30.9	NA	1.4	10.4	22.8	14.7
New York	5,252.5	24.1	8.4	22.1	14.6	5.1	2.8
North Carolina	477.9	28.0	1.6	15.2	12.7	16.6	7.7
North Dakota	62.1	19.6	3.8	32.5	NA	20.7	7.3
Ohio	1,005.4	28.5	1.8	17.5	7.4	15.2	7.5
Oklahoma	353.1	27.2	2.0	NA	9.6	39.9	8.0
Oregon	195.4	16.9	3.7	1.8	19.7	30.5	8.9
Pennsylvania	1,255.0	25.3	8.4	20.7	19.9	8.6	2.6
Puerto Rico	97.8	27.4	NA	NA	NA	NA	NA
Rhode Island	186.6	35.7	NA	1.2	15.4	31.4	3.2
South Carolina	258.9	20.7	.7	9.1	11.2	28.4	11.1
South Dakota	68.1	17.9	2.6	5.0	15.9	43.3	6.4
Tennessee	423.5	22.4	2.9	2.8	12.3	30.3	8.4
Texas	1,144.5	18.0	NA	3.6	16.8	37.9	9.7
Utah	99.0	21.9	2.1	6.5	19.0	28.1	8.9
Vermont	71.1	19.3	3.2	1.4	16.0	31.6	11.7
Virgin Islands	1.9	50.9	NA	NA	NA	NA	2.3
Virginia	429.0	22.2	1.2	1.9	16.5	30.8	8.8
Washington	424.1	22.0	1.2	31.1	15.4	1.8	8.7
West Virginia	124.7	42.5	NA	.2	.9	29.1	8.9
Wisconsin	834.4	13.4	1.5	34.8	9.1	16.8	3.6
Wyoming	16.9	25.2	NA	11.5	NA	47.5	10.2

See footnotes at end of table.

Table 4.17—Continued

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Type of service								
	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
1981	Percent distribution								
All jurisdictions	2.0	.9	5.2	1.4	.5	1.6	5.6	.5	2.5
Alabama	1.4	.4	4.6	NA	1.3	.6	8.6	.7	.7
Alaska	1.9	.9	3.0	.4	NA	.1	NA	.1	2.8
Arkansas	1.9	.4	2.8	.4	.2	.2	8.5	.5	3.1
California	3.2	1.9	5.4	.7	1.0	.1	6.1	.5	6.8
Colorado	1.0	1.1	5.0	4.2	.3	.5	5.6	.4	1.0
Connecticut	1.1	.8	4.8	1.3	.4	1.1	4.7	.1	1.7
Delaware	.9	.4	6.6	.1	.5	1.0	4.4	1.8	.3
District of Columbia	.8	.7	11.6	.5	.5	2.3	3.8	.3	1.7
Florida	2.1	.6	5.6	NA	.1	.3	9.4	.2	1.4
Georgia	2.1	.4	4.3	1.7	.1	.8	10.2	.6	1.8
Hawaii	6.7	1.1	3.7	8.4	.7	.3	4.3	1.0	1.7
Idaho	1.5	.2	3.9	NA	1.8	.4	4.1	.5	3.5
Illinois	3.1	.8	3.9	2.9	.6	.3	7.5	.5	1.3
Indiana	.9	.5	2.2	.2	.2	.4	7.4	.2	1.7
Iowa	3.5	1.1	2.8	.3	.1	.4	5.6	.9	1.1
Kansas	2.3	.9	3.0	1.1	.3	.3	6.6	.7	.9
Kentucky	2.8	.5	4.9	3.4	.1	1.4	4.6	.8	.9
Louisiana	1.5	NA	3.8	1.0	.2	.1	10.6	.6	2.2
Maine	1.4	.8	5.7	.7	NA	1.2	6.5	.1	2.3
Maryland	1.6	.8	10.0	NA	.4	.4	5.5	—	.4
Massachusetts	2.0	.7	6.4	1.7	.3	1.2	4.2	.2	1.6
Michigan	2.0	.8	3.4	.1	1.3	.3	5.9	1.1	3.1
Minnesota	2.3	1.3	2.3	.4	NA	.5	4.0	.4	3.0
Mississippi	2.2	.4	3.3	NA	.2	.4	11.5	.8	.9
Missouri	3.5	1.2	4.9	1.9	.3	.3	8.4	.5	.7
Montana	3.1	1.6	2.7	.9	.2	.5	4.8	.2	2.2
Nebraska	1.5	1.0	2.4	1.5	.5	.9	7.1	.3	.9
Nevada	1.9	.8	2.8	NA	.3	.7	3.7	.6	2.1
New Hamshire	.9	.7	3.2	1.5	.2	1.0	4.6	.4	1.2
New Jersey	3.0	1.1	6.7	.6	.6	1.4	6.1	.5	1.3
New Mexico	3.0	1.1	4.7	.6	.3	.7	6.9	.3	2.1
New York	.8	.3	7.3	2.4	.4	6.3	2.3	.4	2.7
North Carolina	3.0	.4	3.1	1.9	.5	.5	7.2	.7	1.0
North Dakota	3.3	1.2	1.5	1.3	.3	NA	5.3	.1	3.0
Ohio	1.8	1.4	7.1	.6	.5	.1	9.2	.1	1.4
Oklahoma	1.2	.1	.3	NA	.8	NA	3.4	.2	7.3
Oregon	3.2	1.4	3.8	NA	1.7	.1	5.2	.3	2.7
Pennsylvania	2.4	.6	2.7	2.5	.4	.2	5.1	.3	.4
Puerto Rico	NA	NA	72.6	NA	NA	NA	NA	NA	NA
Rhode Island	1.9	.3	4.0	NA	.2	.2	4.9	.3	1.2
South Carolina	2.1	.6	3.8	NA	.2	.6	8.4	.4	2.6
South Dakota	.8	.3	2.0	1.0	.1	NA	3.2	.3	1.3
Tennessee	1.2	.2	4.0	2.8	.9	.5	10.4	.2	.7
Texas	.6	.7	2.1	NA	1.0	.1	6.5	.4	2.4
Utah	2.3	1.0	2.7	.6	.7	.2	4.5	.5	1.0
Vermont	1.6	.8	4.0	NA	1.0	1.9	5.5	.8	1.2
Virgin Islands	.5	NA	30.7	NA	.3	.2	10.0	.6	4.4
Virginia	1.4	.4	5.5	1.1	.1	.5	6.3	.6	2.7
Washington	3.3	1.4	3.3	.1	.8	.7	4.6	.4	5.2
West Virginia	2.0	1.0	3.2	.5	.2	.2	8.7	.2	2.3
Wisconsin	2.6	1.7	3.3	3.3	.1	.5	4.9	2.7	1.9
Wyoming	1.3	.5	2.9	NA	.1	.1	NA	.5	.3

See footnotes at end of table.

Table 4.17—Continued

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Total payments in millions	Type of service					
		Inpatient hospital		Skilled nursing facility	Intermediate care facility		Physicians'
		General hospital	Mental hospital		Mentally retarded	All other	
1982		Percent distribution					
All jurisdictions	$29,399.5	26.1	3.3	15.1	11.8	16.9	7.1
Alabama	338.1	24.6	.3	3.8	8.7	32.9	11.3
Alaska	50.4	18.2	NA	8.8	21.9	34.9	7.0
Arkansas	266.6	16.4	.1	11.5	12.8	32.5	9.4
California	3,536.5	35.5	2.4	18.5	1.2	.7	14.6
Colorado	244.0	19.0	3.6	10.6	16.8	24.7	4.9
Connecticut	358.3	17.5	2.5	45.4	9.8	5.3	3.8
Delaware	55.8	25.7	2.9	0.3	14.5	30.6	9.9
District of Columbia	178.9	53.7	NA	1.8	2.5	12.3	8.5
Florida	553.4	32.1	1.1	10.3	8.6	22.6	7.4
Georgia	569.6	27.3	NA	13.2	9.0	20.4	9.8
Hawaii	125.0	21.6	NA	18.6	8.8	19.3	14.6
Idaho	63.5	17.7	NA	11.7	23.0	25.9	6.8
Illinois	1,344.4	32.9	.6	8.7	10.8	19.0	7.8
Indiana	494.8	23.5	12.3	NA	7.6	37.7	5.2
Iowa	287.3	21.1	1.1	.8	18.2	34.8	8.5
Kansas	233.1	22.7	3.9	.8	17.4	31.7	7.1
Kentucky	341.3	24.9	1.1	8.3	9.7	27.6	11.9
Louisiana	577.8	20.1	.6	.8	19.5	33.2	8.0
Maine	177.8	23.3	NA	1.6	8.9	41.2	6.8
Maryland	417.7	29.9	NA	NA	11.7	34.2	6.4
Massachusetts	1,207.5	34.5	2.0	16.3	10.5	14.7	3.7
Michigan	1,292.6	27.7	2.3	7.3	11.6	18.4	11.8
Minnesota	795.5	14.8	1.2	30.1	19.5	16.0	5.3
Mississippi	262.9	26.6	NA	17.5	7.0	20.6	9.5
Missouri	384.4	25.3	.2	.8	10.7	38.3	5.4
Montana	86.5	20.5	.3	2.5	6.0	45.0	9.5
Nebraska	134.9	20.5	2.7	4.8	15.8	34.6	6.4
Nevada	65.4	34.5	.3	2.0	8.7	32.5	9.9
New Hampshire	86.7	12.0	4.6	1.1	7.3	58.9	3.2
New Jersey	874.7	25.1	4.8	2.3	15.0	27.1	5.4
New Mexico	97.5	31.2	NA	1.5	12.2	22.6	13.5
New York	5,585.9	23.6	9.2	23.8	14.3	4.8	2.5
North Carolina	482.8	25.6	1.3	16.8	16.0	17.8	6.7
North Dakota	65.9	18.4	4.1	35.0	.8	22.4	6.2
Ohio	1,227.1	29.9	1.8	16.8	9.2	14.5	6.8
Oklahoma	361.6	26.2	2.7	NA	9.0	39.9	8.2
Oregon	187.9	17.5	1.0	1.8	21.0	33.2	9.2
Pennsylvania	1,651.8	24.0	6.8	23.9	20.6	9.3	2.0
Puerto Rico	116.0	27.4	NA	NA	NA	NA	NA
Rhode Island	201.0	35.7	NA	1.2	15.4	31.4	3.2
South Carolina	278.9	21.6	4.5	9.2	11.9	30.7	8.6
South Dakota	76.9	18.9	3.2	2.4	19.4	38.3	6.5
Tennessee	464.3	22.4	2.9	2.8	12.3	30.3	8.4
Texas	1,157.5	19.1	NA	2.7	19.6	32.3	10.2
Utah	97.9	23.3	2.1	4.4	21.0	27.4	9.1
Vermont	78.4	16.4	4.3	1.2	21.6	28.4	5.5
Virgin Islands	3.2	50.9	NA	NA	NA	NA	2.3
Virginia	472.6	23.4	.9	2.2	17.3	31.7	8.3
Washington	425.9	20.1	1.1	33.9	18.5	1.9	7.6
West Virginia	121.0	38.4	NA	NA	.7	34.7	10.1
Wisconsin	820.9	15.6	1.4	32.3	7.8	19.6	3.9
Wyoming	18.9	26.9	NA	8.1	NA	48.5	9.4

See footnotes at end of table.

Table 4.17—Continued

Percent distribution of Medicaid payments, by type of service and jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	Type of service								
	Dental	Other practitioners'	Outpatient hospital	Clinic	Laboratory or radiological	Home health	Prescribed drugs	Family planning	Other
1982					Percent distribution				
All jurisdictions	1.7	.8	4.9	1.4	.5	1.7	5.4	.5	2.9
Alabama	1.6	.4	3.7	NA	1.6	.7	8.4	1.2	1.0
Alaska	1.9	.9	3.0	.4	NA	NA	NA	.1	2.8
Arkansas	1.2	.4	3.0	.4	.2	.4	7.9	.3	3.5
California	3.5	1.8	5.6	.8	1.0	.1	6.5	.5	7.3
Colorado	1.1	1.1	4.9	4.4	.3	1.0	5.9	.5	1.1
Connecticut	.9	.7	4.9	1.3	.3	.9	4.9	.4	1.6
Delaware	.9	.4	7.3	.1	.2	1.1	4.4	1.5	.3
District of Columbia	.7	.6	8.5	3.7	.4	2.4	3.8	.2	.8
Florida	1.8	.3	4.8	NA	.1	.6	8.8	.2	1.5
Georgia	1.8	.4	4.5	1.7	.1	1.1	8.4	.7	1.7
Hawaii	5.1	1.0	3.4	.6	.7	.3	4.2	.7	1.2
Idaho	1.2	.2	3.8	NA	1.7	.4	3.9	.5	3.3
Illinois	2.1	.5	3.8	2.4	.6	.2	6.8	.7	3.2
Indiana	.9	.5	2.2	.2	.2	.4	7.4	.2	1.7
Iowa	3.0	.9	3.1	.3	.1	.4	5.6	1.0	1.1
Kansas	1.5	.7	3.6	1.1	.5	.3	6.7	.8	1.1
Kentucky	1.6	.5	4.1	3.4	.1	1.5	4.6	.5	.3
Louisiana	1.1	NA	3.7	1.1	.2	.2	9.0	.7	1.8
Maine	1.1	.9	5.6	.7	NA	1.3	5.8	.6	2.2
Maryland	1.1	.6	9.2	NA	.4	.6	5.3	NA	.4
Massachusetts	1.6	.5	6.9	1.8	.3	1.2	4.1	.2	1.8
Michigan	1.8	.7	5.3	.1	1.2	.3	5.5	1.2	4.7
Minnesota	1.7	2.9	2.4	.3	NA	.5	3.7	.4	1.3
Mississippi	2.0	.4	3.3	NA	.2	.4	10.8	.7	1.0
Missouri	2.0	.7	6.7	2.0	.3	.2	6.0	.6	.8
Montana	3.1	1.6	2.7	.9	.2	.5	4.8	.2	2.2
Nebraska	1.5	1.0	2.4	.7	.6	.9	7.1	.3	.9
Nevada	1.6	.6	2.7	.1	.3	.8	3.7	.6	1.9
New Hampshire	.7	.5	3.4	2.3	.2	.5	3.9	.4	1.1
New Jersey	2.3	.9	6.6	.7	.6	1.4	6.2	.4	1.2
New Mexico	2.3	.8	5.2	.5	.3	.7	7.0	.3	1.8
New York	.7	.4	5.1	2.5	.5	6.9	2.5	.3	3.0
North Carolina	2.5	.3	2.5	1.2	.9	.5	6.5	.3	1.1
North Dakota	2.6	1.0	1.7	1.0	.2	.1	5.2	.2	1.2
Ohio	1.6	1.2	7.4	.5	.5	.1	7.9	.1	1.5
Oklahoma	1.0	.1	.3	NA	.8	NA	3.4	.1	8.4
Oregon	1.3	1.2	4.0	NA	NA	.1	6.1	.2	3.2
Pennsylvania	2.1	.3	2.8	2.2	.4	.2	4.6	.3	.5
Puerto Rico	NA	NA	72.6	NA	NA	NA	NA	NA	NA
Rhode Island	1.9	.3	4.0	NA	.2	.2	4.9	.3	1.2
South Carolina	1.4	.3	3.1	NA	.1	.4	6.0	.4	1.7
South Dakota	.7	.3	.2.5	1.1	.1	.1	3.8	.3	2.3
Tennessee	1.2	.2	4.0	2.8	.9	.5	10.4	.2	.7
Texas	.6	.7	2.4	NA	1.2	.1	6.6	.4	4.0
Utah	1.8	.5	2.6	1.5	.5	.3	3.7	.6	1.2
Vermont	1.3	1.1	5.0	5.3	.1	1.8	4.9	.3	2.9
Virgin Islands	.5	NA	30.7	NA	.3	.2	10.0	.6	4.4
Virginia	1.1	1.3	4.6	1.0	.2	.6	6.3	.4	.7
Washington	1.4	1.1	3.1	.1	.8	.6	4.6	.3	4.9
West Virginia	1.5	.6	2.9	.5	.3	.3	6.9	.5	2.6
Wisconsin	1.7	1.1	3.5	3.8	.1	.6	4.5	.4	3.8
Wyoming	1.4	.6	3.7	NA	.2	.2	NA	.7	.4

SOURCE: Health Care Financing Administration, Office of the Actuary: Annual Medicaid statistics, unpublished data.

Table 4.18

Ratio of Medicaid recipients to persons at or below poverty level, payment per recipient, and per capita personal income, by State: Fiscal year 1982

State	Ratio of Medicaid recipients to persons living at or below poverty level[1]	Payment per recipient[2]	Per capita personal income
Average	45	$1,453	$11,100
Hawaii	104	1,225	11,614
California	83	944	12,616
Rhode Island	77	1,622	10,751
Michigan	72	1,100	10,942
Massachusetts	69	1,803	12,153
Wisconsin	67	1,785	10,725
Pennsylvania	64	1,504	10,934
New York	60	2,604	12,389
Vermont	60	1,446	9,478
Illinois	58	1,264	12,091
Maine	53	1,399	9,031
New Jersey	53	1,375	13,169
District of Columbia	51	1,650	15,064
Maryland	50	1,292	12,237
Minnesota	49	2,461	11,155
Ohio	47	1,397	10,667
Connecticut	45	1,813	13,810
Kansas	38	1,576	11,717
Alaska	37	1,964	16,598
Oklahoma	37	1,490	11,247
West Virginia	37	679	8,758
Delaware	36	1,157	11,810
Missouri	36	1,137	10,188
Washington	35	1,683	11,466
Montana	34	1,631	9,544
Iowa	34	1,600	10,754
Kentucky	34	968	8,893
Oregon	34	1,134	10,231
Mississippi	33	866	7,725
New Hampshire	33	1,979	10,721
Georgia	31	1,301	9,573
Louisiana	31	1,486	10,211
South Carolina	30	1,115	8,475
Virginia	29	1,481	11,056
Nebraska	28	1,735	10,641
Tennessee	28	1,279	8,899
Arkansas	27	1,358	8,424
Colorado	27	1,699	12,202
Indiana	25	2,076	9,994
New Mexico	25	1,076	9,135
North Carolina	25	1,365	9,048
Alabama	24	1,051	8,647
Florida	24	1,064	10,907
Nevada	22	2,249	12,022
North Dakota	22	2,121	10,830
Utah	21	1,644	8,820
Texas	20	1,712	11,423
Wyoming	20	1,558	12,211
Idaho	18	1,594	8,937
South Dakota	17	2,157	9,582

[1] Numerators were calculated from data submitted by the States to the Health Care Financing Administration (HCFA). Numerators for 4 States were estimated from 1980 data. Data from Pennsylvania were adjusted because of a sampling problem. Numerators are estimates of total number of persons receiving Medicaid services in each State regardless of whether Federal monies were involved. Denominators were developed from U.S. Bureau of Census data. Denominators were adjusted to include estimates of nonpoor receiving Medicaid.

[2] This average was calculated by dividing total expenditures, exclusive of non-Medicaid recipient payments, by the total number of Medicaid recipients as reported to HCFA.

SOURCE: Health Care Financing Administration Office of the Actuary: Annual Medicaid statistics, unpublished data.

The total administration, training, and medical vendor payments subject to Federal financial participation (FFP), along with the Federal and State share of such payments in FY 1981 and 1982 are shown in Table 4.20. Expenditure data shown in Table 4.20 may differ from expenditure figures in other tables because total payments computable for Federal funding represent only those payments for which FFP is allowed. Payments for which FFP is not allowed, such as Medicare supplementary medical insurance (SMI) premiums paid on behalf of the medically needy, are excluded. The *unadjusted Federal Share* does not reflect accounting adjustments, such as changes in payments to cost-reimbursed providers following year-end audits.

Local funding formulas

The non-Federal share of medical vendor payments may be provided out of State or local revenues. However, a State plan must ensure that at least 40 percent of the non-Federal share is borne directly by the State. It must also guarantee that lack of local funds will not result in smaller amounts, duration, scope, or quality of care provided to Medicaid eligibles. As of February 1982, 14 States provided for local funding of the non-Federal share of Medicaid vendor payments. Table 4.21 presents the local funding formulas used by these States in March 1983.

State buy-in with Medicare

If individuals eligible for Medicaid under a State plan also qualify for Medicare SMI coverage, the State can enroll them by paying their SMI premiums. Under this buy-in arrangement, some of the cost of providing care that would otherwise be borne by the State is instead borne by the Federal Government. (For a more detailed discussion, see Chapter 1.)

The number of individuals enrolled in Medicare SMI under a buy-in arrangement in CY 1982 is shown in Table 4.22. Also included are the number of such individuals receiving reimbursed services and the total payments made under Medicare's SMI program on behalf of Medicaid beneficiaries. All but four jurisdictions buy into the Medicare SMI program.

Table 4.19

Federal Medicaid assistance percentages, by jurisdiction: 1966-85

Medicaid jurisidiction	Jan. 1, 1966-June 30, 1967	July 1, 1969-June 30, 1971	July 1, 1971-June 30, 1973	July 1, 1973-June 30, 1975	July 1, 1975-Sept. 30, 1977	Oct. 1, 1977-Sept. 30, 1979	Oct. 1, 1979-Sept. 30, 1981	Oct. 1, 1981-Sept. 30, 1983	Oct. 1, 1983-Sept. 30, 1985
Alabama	79.85	78.54	78.43	75.93	73.79	72.58	71.32	71.13	72.14
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Arizona[1]	63.94	66.42	64.15	61.92	60.48	60.81	61.47	59.87	61.21
Arkansas	81.67	79.76	79.42	76.31	74.60	72.06	72.87	72.16	73.65
California	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	53.08	56.24	57.61	57.22	54.69	53.71	53.16	52.28	50.00
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
District of Columbia	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Florida	65.21	64.10	60.67	60.95	57.34	56.65	58.94	57.92	58.41
Georgia	74.91	71.48	69.67	66.96	66.10	65.82	66.76	66.28	67.43
Guam	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Hawaii	52.97	50.75	50.83	50.00	50.00	50.00	50.00	50.00	50.00
Idaho	70.73	68.91	71.56	69.50	68.18	63.38	65.70	65.40	67.28
Illinois	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Indiana	55.77	52.85	55.05	57.01	57.47	57.86	57.28	56.73	59.93
Iowa	60.39	55.27	58.07	59.72	57.13	51.96	56.57	55.35	55.24
Kansas	61.45	57.78	59.06	55.37	54.02	52.35	53.52	52.50	50.67
Kentucky	76.70	74.30	73.49	72.12	71.37	69.71	68.07	67.95	70.72
Louisiana	76.41	73.57	73.49	72.80	72.41	70.45	68.82	66.85	64.45
Maine	69.57	68.33	69.43	70.03	70.60	69.74	69.53	70.63	70.63
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	51.62	51.75	53.56	50.13
Michigan	50.31	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.70
Minnesota	60.46	56.95	56.82	57.37	56.84	55.26	55.64	54.39	52.67
Mississippi	83.00	83.00	83.00	80.55	78.28	78.09	77.55	77.36	77.63
Missouri	53.90	59.29	59.53	59.94	58.98	60.66	60.36	60.38	61.40
Montana	62.86	64.72	67.16	66.08	63.21	61.10	64.28	65.34	64.41

See footnotes at end of table.

Table 4.19—Continued

Federal Medicaid assistance percentages, by jurisdiction: 1966-85

Medicaid jurisidiction	Jan. 1, 1966-June 30, 1967	July 1, 1969-June 30, 1971	July 1, 1971-June 30, 1973	July 1, 1973-June 30, 1975	July 1, 1975-Sept. 30, 1977	Oct. 1, 1977-Sept. 30, 1979	Oct. 1, 1979-Sept. 30, 1981	Oct. 1, 1981-Sept. 30, 1983	Oct. 1, 1983-Sept. 30, 1985
Nebraska	60.39	57.25	58.48	57.86	55.59	53.46	57.62	58.12	57.13
Nevada	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Hampshire	61.31	59.18	59.36	62.05	60.28	62.85	61.11	59.41	59.45
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	70.73	71.48	72.63	72.01	73.29	71.84	69.03	67.19	69.39
New York	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.88	50.00
North Carolina	75.58	73.96	72.84	70.01	68.03	67.81	67.64	67.81	69.54
North Dakota	66.67	70.48	71.28	70.12	57.59	50.71	61.44	62.11	61.32
Ohio	52.33	52.42	53.65	53.59	53.39	55.46	55.10	55.10	55.44
Oklahoma	70.32	68.84	69.02	68.07	67.42	65.42	63.64	59.91	58.47
Oregon	54.12	56.35	57.39	59.40	59.04	57.29	55.66	52.81	57.12
Pennsylvania	54.38	54.60	55.45	55.14	55.39	55.11	55.14	56.78	56.04
Puerto Rico	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Rhode Island	56.13	51.70	50.26	55.37	56.55	57.00	57.81	57.77	58.17
South Carolina	81.30	78.68	78.00	75.00	73.58	71.93	70.97	70.77	73.51
South Dakota	71.05	69.91	69.69	70.25	67.23	63.80	68.78	68.19	68.31
Tennessee	76.86	74.62	74.35	72.28	70.43	68.88	69.43	68.53	70.66
Texas	67.27	65.66	65.18	63.53	63.59	60.66	58.35	55.75	54.37
Utah	66.30	68.23	69.88	69.95	70.04	68.98	68.07	68.64	70.84
Vermont	68.44	64.96	64.71	65.38	69.82	68.02	68.40	69.37	68.59
Virgin Islands	55.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Virginia	66.96	65.04	64.03	61.58	58.34	57.01	56.54	56.74	56.53
Washington	50.81	50.00	50.00	53.13	53.72	51.64	50.00	50.00	50.00
West Virginia	74.27	75.73	76.97	73.52	71.90	70.16	67.35	67.95	70.57
Wisconsin	57.60	55.21	56.28	60.02	59.91	58.53	57.95	58.02	56.87
Wyoming	55.47	60.38	62.73	60.99	60.94	53.44	50.00	50.00	50.00

[1] Not applicable; no Title XIX program in effect.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Unpublished data.

Table 4.20

Medicaid payments eligible for Federal Financial Participation, by type of payment and jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	All payments	Type of payment: Medical assistance — Total computable	Medical assistance — Unadjusted Federal share	Medical assistance — State share	Administration and training — Total computable	Administration and training — Unadjusted Federal share	Administration and training — State share
1981			Amount in millions				
United States	$29,676.4	$28,353.8	$15,707.6	$12,647.1	$1,324.6	$781.5	$543.0
Alabama	301.7	291.6	212.8	78.8	10.1	7.2	2.9
Alaska	46.4	44.3	23.2	21.1	2.1	1.2	.9
Arkansas	290.2	281.2	205.1	76.1	9.0	5.4	3.6
California	3,924.0	3,733.5	1,873.2	1,860.3	190.5	105.6	84.9
Colorado	226.3	217.8	116.4	101.4	8.5	5.4	3.1
Connecticut	396.7	379.8	190.5	189.3	16.9	9.5	7.4
Delaware	57.6	55.2	28.1	27.1	2.4	1.4	1.0
District of Columbia	169.2	160.1	80.1	80.1	9.1	5.5	3.6
Florida	540.3	512.5	302.5	210.0	27.8	18.1	9.7
Georgia	577.2	553.8	370.4	183.4	23.4	14.6	8.8
Hawaii	116.3	111.1	56.0	55.1	5.2	3.4	1.8
Idaho	63.7	60.2	39.7	20.5	3.5	2.2	1.3
Illinois	1,536.9	1,481.9	743.6	738.3	55.0	29.7	25.3
Indiana	467.2	448.9	257.4	191.5	18.3	10.4	7.9
Iowa	287.7	278.0	158.0	120.0	9.7	5.6	4.1
Kansas	231.0	222.8	119.5	103.3	8.2	4.8	3.4
Kentucky	388.7	371.3	253.4	117.9	17.4	10.1	7.3
Louisiana	438.6	420.5	299.0	121.5	18.1	10.0	8.1
Maine	169.3	162.3	112.9	49.4	7.0	4.2	2.8
Maryland	500.7	480.7	241.3	239.4	20.0	11.1	8.9
Massachusetts	1,188.5	1,160.0	601.3	558.7	28.5	15.1	13.4
Michigan	1,435.3	1,375.5	691.4	684.1	59.8	36.4	23.4
Minnesota	704.7	679.6	379.2	300.4	25.1	14.1	11.0
Mississippi	264.7	253.4	196.9	56.5	11.3	6.7	4.6
Missouri	397.9	383.8	232.6	151.2	14.1	8.1	6.0
Montana	92.1	87.7	56.7	31.0	4.4	2.6	1.8
Nebraska	134.5	126.5	73.0	53.5	8.0	4.8	3.2
Nevada	66.5	62.2	31.2	31.0	4.3	2.3	2.0
New Hampshire	89.0	84.5	51.7	32.8	4.5	2.8	1.7
New Jersey	879.5	846.9	425.4	421.5	32.6	22.5	10.1
New Mexico	97.9	91.9	64.0	27.9	6.0	3.7	2.3
New York	5,330.3	5,072.5	2,557.3	2,515.2	257.8	154.1	103.7
North Carolina	514.3	486.5	329.8	156.7	27.8	14.3	13.5
North Dakota	65.0	60.6	37.4	23.2	4.4	2.6	1.8
Ohio	1,096.9	1,054.1	585.2	468.9	42.8	23.7	19.1
Oklahoma	389.3	361.7	230.5	131.2	27.6	16.3	11.3
Oregon	218.4	199.0	109.6	89.4	20.7	12.2	8.5
Pennsylvania	1,560.9	1,492.9	824.6	668.3	68.0	38.4	29.6
Rhode Island	189.8	183.4	106.3	77.1	6.4	3.8	2.6
South Carolina	311.8	300.9	213.8	87.1	10.9	6.2	4.7
South Dakota	75.0	72.2	50.1	22.1	2.8	1.8	1.0
Tennessee	451.0	434.7	302.4	132.3	16.3	10.4	5.9
Texas	1,288.4	1,200.3	701.8	498.5	88.1	56.7	31.4
Utah	98.7	92.6	63.1	29.5	6.1	3.8	2.3
Vermont	76.3	71.6	49.0	22.6	4.7	3.1	1.6
Virginia	458.5	441.0	250.4	190.6	17.5	10.6	6.9
Washington	438.3	415.8	212.6	203.2	22.5	14.2	8.3
West Virginia	137.9	129.0	86.9	42.1	8.9	5.3	3.6
Wisconsin	877.5	849.9	501.5	347.2	29.6	19.1	10.4
Wyoming	17.8	16.9	8.5	8.4	.9	.4	.5

See footnotes at end of table.

Table 4.20—Continued

Medicaid payments eligible for Federal Financial Participation, by type of payment and jurisdiction: Fiscal years 1981 and 1982

Year and Medicaid jurisdiction	All payments	Type of payment					
		Medical assistance			Administration and training		
		Total computable	Unadjusted Federal share	State share	Total computable	Unadjusted Federal share	State share
1982							
United States	$31,661.5	$30,203.1	$16,698.1	$13,505.0	$1,458.4	$868.7	$589.7
Alabama	330.6	319.8	228.2	91.6	10.8	7.5	3.3
Alaska	46.2	43.8	23.3	20.5	2.4	1.3	1.1
Arkansas	283.7	274.1	198.0	76.1	9.6	5.7	3.9
California	4,026.9	3,794.7	1,904.8	1,889.9	232.2	136.7	95.5
Colorado	251.9	240.0	126.0	114.0	11.9	8.1	3.8
Connecticut	462.9	442.1	221.4	220.7	20.8	11.4	9.4
Delaware	60.3	57.9	29.4	28.5	2.4	1.5	.9
District of Columbia	198.2	186.6	93.4	93.2	11.6	6.4	5.2
Florida	616.8	584.8	339.1	245.7	32.0	21.0	11.0
Georgia	607.5	588.4	390.6	197.8	19.1	12.8	6.3
Hawaii	128.9	124.3	62.5	61.8	4.6	2.9	1.7
Idaho	63.0	59.6	39.2	20.4	3.4	2.2	1.2
Illinois	1,506.1	1,448,6	728.1	720.5	57.5	29.6	27.9
Indiana	536.1	515.6	293.5	222.1	20.5	12.0	8.5
Iowa	306.0	294.0	163.5	130.5	12.0	7.0	5.0
Kansas	244.1	235.7	124.0	111.7	8.4	4.9	3.5
Kentucky	400.0	378.8	257.6	121.2	21.2	12.6	8.6
Louisiana	558.9	537.4	360.2	177.2	21.5	11.5	10.0
Maine	188.3	180.2	127.5	52.7	8.1	4.9	3.2
Maryland	514.2	491.7	246.7	245.0	22.5	12.7	9.8
Massachusetts	1,272.6	1,238.8	664.7	574.1	33.8	18.1	15.7
Michigan	1,500.2	1,435.0	721.2	713.8	65.2	40.0	25.2
Minnesota	828.6	800.9	436.9	364.0	27.7	15.6	12.1
Mississippi	283.2	275.0	213.2	61.8	8.2	5.2	3.0
Missouri	431.0	417.6	253.1	164.5	13.4	8.0	5.4
Montana	93.5	88.6	58.3	30.3	4.9	2.6	2.3
Nebraska	143.8	135.8	79.1	56.7	8.0	4.8	3.2
Nevada	71.1	65.9	33.1	32.8	5.2	2.8	2.4
New Hampshire	92.8	87.8	52.3	35.5	5.0	3.1	1.9
New Jersey	917.6	887.1	444.9	442.2	30.5	21.0	9.5
New Mexico	106.8	100.5	68.3	32.2	6.3	3.9	2.4
New York	5,900.7	5,609.5	2,864.6	2,744.9	291.2	171.7	119.5
North Carolina	524.5	494.2	335.7	158.5	30.3	17.3	13.0
North Dakota	72.0	66.9	41.8	25.1	5.1	3.0	2.1
Ohio	1,305.4	1,263.0	700.7	562.3	42.4	23.4	19.0
Oklahoma	403.6	371.0	222.7	148.3	32.6	19.0	13.6
Oregon	224.6	200.6	106.3	94.3	24.0	14.5	9.5
Pennsylvania	1,734.4	1,656.5	942.0	714.5	77.9	46.8	31.1
Rhode Island	203.8	197.2	114.0	83.2	6.6	3.9	2.7
South Carolina	301.1	290.4	205.8	84.6	10.7	6.6	4.1
South Dakota	80.6	78.0	53.6	24.4	2.6	1.6	1.0
Tennessee	421.6	407.6	279.7	127.9	14.0	9.0	5.0
Texas	1,271.3	1,181.3	660.4	520.9	90.0	57.5	32.5
Utah	117.4	107.8	74.2	33.6	9.6	6.3	3.3
Vermont	84.2	78.2	53.7	24.5	6.0	3.9	2.1
Virginia	498.0	478.1	272.6	205.5	19.9	11.9	8.0
Washington	424.3	402.3	202.1	200.2	22.0	13.7	8.3
West Virginia	133.0	122.7	83.4	39.3	10.3	6.5	3.8
Wisconsin	867.9	846.3	492.5	353.8	21.6	13.8	7.8
Wyoming	21.3	20.4	10.2	10.2	.9	.5	.4

SOURCE: Health Care Financing Administration, A Bureau of Program Operations: HCFA-64 Quarterly Report, unpublished data.

Administrative practices

Methods of reimbursement and cost-containment

Medicaid regulations specify several criteria and methods for reimbursing providers. The method of reimbursement for inpatient hospital services, long-term care services, outpatient hospital services, and physicians' services is shown by State in Table 4.23.

Before FY 1982, States were required by law to reimburse for inpatient hospital services on the same basis as Medicare, reasonable costs, unless the Secretary of the Department of Health and Human Services approved an alternative method of reimbursement. This requirement was dropped by Section 2173 of OBRA-81. In its place, States were required only to provide assurances satisfactory to the Secretary that the rates paid to hospitals:

- Are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in accordance with applicable laws and quality and safety standards.
- Take into account the unusual costs incurred by hospitals, especially public and teaching hospitals, which serve large numbers of low-income patients.
- Provide reasonable access to inpatient hospital services of adequate quality.
- Are routinely documented through uniform cost reports filed by each hospital and through periodic State audits of such reports (42 CFR 447.252).

For all other services, States are free to choose their own method of payment as long as the aggregate Medicaid payment levels do not exceed the amounts that would be paid under Medicare. As of March 1983, 26 States reported using Medicare principles for inpatient hospital services, 27 for outpatient hospital services, and 20 States for physicians' services. States must ensure that their payment systems for SNF and ICF services are reasonably related to cost. Use of a cost-related payment system for long-term care institutional services has been required by law since July 1, 1976, but became fully operational in different States at different times after that date.

Before October 1, 1981, Medicaid eligibles were free to choose any provider, practitioner, or supplier of health services covered by a State's Medicaid program. However, the Secretary of Health and Human Services was authorized to waive certain Federal Medicaid requirements to enable States to conduct experimental, pilot or demonstration projects which limit freedom of choice, including demonstrations of prospective reimbursement. To provide States more flexibility in implementing various cost-saving measures, Section 2175 of OBRA-81, provides that a State shall not be held out of compliance for failure to meet certain State plan requirements if it limits free choice in any of the following ways:

- Purchases laboratory services and medical devices through a competitive or other arrangement, and the Secretary finds that adequate services or devices were available to beneficiaries.
- Contracts with organizations which agree to provide services in addition to those offered under the State plan to eligible individuals residing in the area served by the organization and who elect to receive care from the organization.
- Pays for certified rural health clinic services.
- "Locks in" beneficiaries who overutilize services to a particular provider for a reasonable time period.

Table 4.21

Local funding formulas for Medicaid vendor payments, by State: March 1983

State	Formula
Colorado	20 largest counties pay 2 percent of State share for all new ICF[1] nursing admissions.
Florida	Counties pays $357 cost or $55/mo., whatever is less, for each nursing home resident; 35 percent of cost for I/P hospital days over 12 and less than 46; 100 percent of State share for outpatient services after the first $100 and less than $500 for each recipient.
Iowa	Counties match Federal funds for ICF-MR's.[2]
Minnesota	Counties pay 10 percent of State share.
Montana	Counties pay 18 percent of eligibility personnel costs.
Nebraska	Counties pay 14 percent of State share.
New Hampshire	Local contributions pay approximately 25 percent of ICF[1] nursing home cost except for nursing home residents living in an institutional setting.
New York	Counties pay 25 percent of State share except for certain LTC[3] services.
North Carolina	Counties pay 15 percent of State share for all services except SNF's[4] and ICF's,[1] for which they pay 35 percent of State share.
North Dakota	Counties pay 15 percent of State share except for ICF-MR,[2] clinic services, and waivered home and community -based services for recipients of services for the mentally retarded.
Pennsylvania	Counties pay 10 percent of State share for county nursing homes plus $3 per invoice administration fee.
South Dakota	$60 per month for each ICF-MR[2] resident and local school district for Crippled Children's Hospital.
Utah	Local contribution of less than 1 percent for specific services such as mental health.
Wisconsin	Local contribution of 10-42 percent for specific services such as mental health.

[1] Intermediate care facility.
[2] Intermediate care facilities for the mentally retarded.
[3] Long-term care.
[4] Skilled nursing facilities.

NOTE: Table includes all States with local funding formulas.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, and La Jolla Management Corporation: *Analysis of State Medicaid Program Characteristics.* Rockville, Md., 1983.

- "Locks out" providers who abuse the program, subject to prior notice and opportunity for a hearing and provided that eligible individuals have reasonable access to services of adequate quality.

Additionally, the provision authorizes the Secretary to waive for a 2-year period certain State plan requirements in order to assist States in improving cost effectiveness in various areas of program operation (TEFRA Section 137 repeals the Secretary's authority to waive health maintenance organization requirements), such as:

- Allowing States to create a primary care case-management system or a physician speciality arrangement.
- Allowing a locality to act as a central broker in helping Medicaid enrollees choose among competing health plans.
- Permitting States to share with recipients in the form of more cost-effective care.
- Restricting providers from whom recipients can obtain services (in other than emergency situations) to those who agree to comply with reasonable State standards.

Federal regulations governing payments for prescription drugs, known as the maximum allowable cost (MAC) system, went into effect in August 1976 (42 CFR 447.332). The MAC regulations place upper limits on Government payments for certain "multisource" prescription drugs and require States to establish estimates of the acquisition cost (known as "estimated acquisition cost" or EAC) of all outpatient drug products prescribed for Medicaid enrollees. The exception to this regulation is that a physician may specify in writing that a higher cost drug is required. For Federal matching purposes, payments for precription drugs may not exceed the MAC limit (plus a reasonable dispensing fee), the EAC estimate (plus a reasonable fee), or the provider's usual and customary charge to the general public, whichever is lowest.

Before October 1, 1981, States could enter into prepaid risk contracts only with federally qualified health maintenance organizations (HMO's). Contracting HMO's were required to have an enrollment consisting of less than 50 percent Medicaid and Medicare patients. Section 2178 of OBRA-81 allows States to enter into prepaid risk contracts not only with qualified HMO's, but also with organizations which: (1) make covered services accessible to Medicare enrollees to the same extent that these services are accessible to Medicaid recipients not enrolled in the organization; and (2) have made adequate provision against the risk of insolvency. (Paticipating organizations also must assure that Medicaid enrollees will not be held liable for debts in the event of the organization's insolvency.) Additionally, these contracts must provide for:

- Access by the Secretary of Health and Human Services and the State to certain books and records of HMO's.
- Nondiscrimination on the basis of health status or use of health services in the entity's enrollment, reenrollment, and disenrollment activities.
- Disenrollment rights for individuals after one full month of membership.
- Reimbursement for medically necessary services received out of plan (under certain circumstances).

Section 2178 also: (1) requires States to continue Medicaid eligibility of the end of an HMO's minimum enrollment period for Medicaid-covered HMO enrollees who would otherwise lose their Medicaid eligibility; (2) raises

Table 4.22
Medicaid eligibles enrolled as Medicare buy-ins, persons served, and reimbursements, by jurisdiction: Calendar year 1982

Medicaid jurisdiction	Number of State buy-ins enrolled in thousands	Number of persons with reimbursed services[1] in thousands	Total reimbursement in millions
All jurisdictions	3,125.6	2,414.1	$2,359.5
Alabama	118.0	83.3	53.4
Alaska[2]	.9	.5	.6
Arkansas	73.1	52.7	36.9
California	639.1	529.7	711.1
Colorado	37.0	30.0	25.3
Connecticut	12.6	10.4	10.9
Delaware	4.2	3.1	3.2
District of Columbia	14.5	11.3	19.8
Florida	142.4	113.0	142.3
Georgia	131.4	98.0	70.8
Guam	.6	.3	.4
Hawaii	10.9	9.0	9.9
Idaho	7.6	5.9	3.4
Illinois	51.6	40.6	45.6
Indiana	46.0	37.0	26.7
Iowa	36.1	26.1	15.9
Kansas	30.5	23.7	17.9
Kentucky	65.1	41.6	24.9
Louisiana[2]	0.0	1.1	1.1
Maine	16.5	12.2	7.8
Maryland	47.6	38.2	41.1
Massachusetts	91.1	69.8	67.9
Michigan	73.6	56.9	63.5
Minnesota	17.7	13.5	10.5
Mississippi	95.5	67.4	39.5
Missouri	56.8	40.8	25.2
Montana	9.0	6.8	5.0
Nebraska	7.8	5.8	4.4
Nevada	6.0	5.4	7.8
New Hampshire	3.4	2.5	2.0
New Jersey	81.5	67.5	81.4
New Mexico	19.2	13.7	11.5
New York	217.0	171.6	183.2
North Carolina	75.7	59.7	48.2
North Dakota	3.8	2.9	2.2
Ohio	94.0	79.6	68.3
Oklahoma	43.5	29.7	18.7
Oregon[2]	.0	1.0	1.0
Pennsylvania	96.4	65.5	72.6
Puerto Rico[2]	.0	1.1	1.0
Rhode Island	10.2	8.0	7.0
South Carolina	70.6	50.0	31.4
South Dakota	6.0	3.7	2.3
Tennessee	90.4	59.6	41.1
Texas	255.4	193.4	170.7
Utah	8.0	6.4	5.2
Vermont	6.4	4.7	2.9
Virgin Islands	.8	.2	.1
Virginia	67.9	51.3	45.1
Washington	47.4	38.1	30.6
West Virginia	23.7	14.7	10.2
Wisconsin	44.6	38.3	13.2
Wyoming[2]	.0	.1	.1

[1] Based on supplementary medical insurance bills (physicians, outpatient services, home health services, and other suppliers of services) paid January 1982—March 1983. Recipient counts and reimbursements correspond to State of residence at the time the bill was processed, which need not be the State which bought in for that person.

[2] No buy-in agreement; therefore, the number of State buy-ins enrolled at any time is zero. It should be noted, however, that recipient counts and reimbursement counts are attributed to a person's State of residence at the time the bill was processed.

SOURCE: Health Care Financing Administration, Bureau of Program Operations: Unpublished data.

Table 4.23

Medicaid reimbursement methods, by type of service and jurisdiction: March 1983

Medicaid jurisdiction	Inpatient hospital services[1]				Outpatient hospital services		Long-term care [2]			Physicians' services		
	Medicare principles	Medicaid only	Medicaid and private payers	All payers	Medicare principles	Other	SNF	ICF	ICF-MR	Medicare principles (percent under prevailing charge)	Fee schedules	
											Fixed fee schedule	Relative value scale
Alabama		1981			x		PFS	PFS	PFS	<75		
Alaska	x				x		RFS	RFS	RFS	80		
Arkansas	x					x	PC	PC	PFS	<75		
California		[3] 1982				x	PC	PC	PC			x
Colorado		1977			x		PFS	PFS	PFS			x
Connecticut	x					x	PFS	PFS	PFS		x	
Delaware	x				x		PFS	PFS	PFS	75		
District of Columbia	x	[4] 1983				x	PFS	PFS	PFS	75		
Florida		1981				x	PFS	PFS	PFS			x
Georgia		1983			x		PFS	PFS	PFS		x	
Hawaii	x					x	RFS	RFS	RFS	75		
Idaho		1980			x		PFS	PFS	PFS		x	
Illinois		1983				x	PFS	PFS	PFS		x	
Indiana	x					x	PFS	PFS	PFS	75		
Iowa		1982			x		RFS	PFS	PFS	75		
Kansas	x				x		PFS	PFS	PFS	75		
Kentucky		1982			x		PFS	PFS	PFS	75		
Louisiana	x				x		PC	PC	PFS	75		
Maine	x				x		COM	PFS	RFS		x	
Maryland				[5] 1977		x	RFS	RFS	RFS		x	
Massachusetts			[6] 1982			x	RFS	RFS	COM		x	
Michigan		1980				x	PFS	PFS	RFS		x	
Minnesota	x				x		PFS	PFS	RFS	<75		
Mississippi		1981			x		PFS	PFS	PFS		x	
Missouri		1981				x	PFS	PFS	PFS		x	
Montana	x				x		PFS	PFS	RFS		x	
Nebraska		1982				x	PFS	PFS	PFS		x	
Nevada	x					x	COM	COM	COM		x	
New Hampshire	x				x		RFS	PFS	PFS		x	
New Jersey				1979		x	PFS	PFS	RFS		x	
New Mexico	x				x		RFS	RFS	RFS	75		
New York		1970				x	PC	PC	PC		x	
North Carolina		1981			x		PFS	PFS	PFS		x	
North Dakota	x				x		COM	COM	COM		x	

See footnotes at end of table.

Table 4.23—Continued

Medicaid reimbursement methods, by type of service and jurisdiction: March 1983

Medicaid jurisdiction	Inpatient hospital services[1]				Outpatient hospital services		Long-term care [2]			Physicians' services		
										Medicare principles (percent under prevailing charge)	Fee schedules	
	Medicare principles	Medicaid only	Medicaid and private payers	All payers	Medicare principles	Other	SNF	ICF	ICF-MR		Fixed fee schedule	Relative value scale
Ohio	x				x		COM	COM	COM	<75		
Oklahoma	x					x	PFS	PFS	PFS	75		
Oregon	x				x		RFS	RFS	RFS	75	x	
Pennsylvania		[7] 1982				x	RFS	RFS	RFS		x	
Rhode Island			[8] 1974			x	PFS	PFS	RFS		x	
South Carolina	x					x	PFS	PFS	RFS		x	
South Dakota	x				x		PFS	PFS	PFS	75		
Tennessee	x				x		RFS	PFS	PFS	<75		
Texas	x				x		PC	PC	PC	75		
Utah	x				x		PC	PC	PC			x
Vermont		1982			x		PC	PC	RFS		x	
Virginia		1982			x		PFS	PFS	PFS		x	
Washington		1982				x	PFS	PFS	PFS			x
West Virginia	x					x	PFS	PFS	PFS		x	
Wisconsin		1981				x	PFS	PFS	PFS		x	
Wyoming	x				x		PFS	PFS	PFS	75		

[1] Year of implementation of alternative reimbursement systems.
[2] Facilities: SNF = skilled nursing facility; ICF = intermediate care facility; ICF-MR = intermediate care facility for the mentally retarded. Reimbursement methods: PFS = prospective facility-specific; RFS = retrospective facility-specific; PC = prospective class rate; COM = combination of other methods.
[3] Short-term only; excludes crossover claims. Expenditure data for calendar year 1982. Selected contracting program not fully implemented in 1982.
[4] Negotiated Maxicap.
[5] Per diem reimbursement based on approved hospital department rates. Payment made as a percent of predetermined charge rates.
[6] Not technically an all-payer system. Medicare does not participate in all-payer system for chronic hospitals. System is based on per diem rate of increase control.
[7] Cost-related with a maximum 10 percent cap on annual increases. Special treatment for high-volume Medicaid hospitals. Going Medicaid-only diagnosis-related group case rates in 1984.
[8] Prospective facility-specific subject to Maxicap. State hospitals reimbursed using Medicare principles.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, and La Jolla Management Corporation: *Analysis of State Medicaid Program Characteristics*. Rockville, Md., 1983.

the previous enrollment limit from no more than 50 percent to no more than 75 percent Medicare and Medicaid patients; and (3) allows the Secretary to modify or waive this last requirement for public HMO's when warranted by special circumstances and when the HMO is making reasonable efforts to enroll individuals from the private sector.

State administration, training, and provider certification

Administration of State Medicaid programs is vested in single State agencies. State plans must designate a medical assistance unit within each agency that is responsible for developing, analyzing, and evaluating the Medicaid program. The law further requires States to establish medical care advisory committees to counsel the Medicaid agency director about health and medical services. These committees must include board-certified physicians and other representatives of the health profession, members of consumer groups, and the director of either the State public welfare or the public health department (whichever department does not run the Medicaid agency).

Medicaid regulations establish certain standards governing personnel administration in State Medicaid programs. First, each State must employ a merit system of personnel administration. Second, the State plan must offer a training program for agency personnel. This program must include inservice training for new staff, be related to job duties, and be consistent with program objectives. Finally, the State plan must provide for the training and effective use of subprofessional staff and unpaid volunteers. Federal financial participation is available to States for administrative and training costs.

Provider participation

The number of participating providers and beds certified for Medicare and Medicaid in inpatient facilities, SNF's, ICF's, and intermediate care facilities for the mentally retarded is shown in Table 4.24. Providers are certified by Medicaid programs regardless of their participation status. Enrolled physicians are generally defined as physicians who have applied for and received a Medicaid provider number. Participating physicians are defined as enrolled physicians who have submitted at least one claim within the past 12-month period.

Eligibility determination level

States are allowed several options for administering mandatory coverage of SSI recipients:

- States electing to extend Medicaid to all SSI recipients can enter into an agreement with the Social Security Administration under Section 1634 of the Social Security Act for determination of Medicaid eligibility. Social Security then provides States with eligibility information so that Medicaid identification cards can be issued and State eligibility files for processing Medicaid claims can be maintained.
- States electing to extend Medicaid eligibility to SSI recipients can maintain eligibility determinations on a State level.
- States electing the 209(b) option (under which recipients of SSI cash assistance are not automatically eligible for Medicaid) can require cash assistance recipients to make a separate application for Medicaid.

The option chosen by each State is listed in Table 4.25. As of March 1983, 31 States had elected Federal determination; five States had elected to extend Medicaid to all recipients of SSI but to maintain eligibility determination on a State level; and 14 had elected to retain their 209(b) status.

Medicaid Management Information System

The Social Security Amendments of 1972 authorized 90-percent Federal matching to States for the costs of design, development, and installation of mechanized claims processing and information retrieval systems and 75-percent matching for the costs of operating such systems.

The Medicaid Management Information System (MMIS) is a general conceptual design that can be tailored by State Medicaid agencies to their own particular needs so long as the system meets federally required minimum performance standards. The conceptual design includes six subsystems: recipient, provider, claims processing, reference file, surveillance and utilization review, and management and administration reporting. The first four subsystems work together with the overall objective of processing and paying each eligible provider for every valid claim. The other two subsystems consolidate and organize data necessary for managing and controlling the Medicaid program.

State progress in developing and implementing MMIS systems is summarized in Table 4.25. Thirty-eight States have mechanized claims processing and information retrieval systems approved for 75-percent FFP. Four States anticipate certification of an MMIS system and 75-percent FFP during FY 1984. Three States are currently in the planning, development, or installation phase, and five States have no active MMIS plan. Statutory authority for MMIS development is Section 235 of Public Law 92-603. Regulations are published in 42 CFR 433, Subpart C.

Review for fraud and abuse

Under Federal law, a State plan must specify criteria and methods for identifying suspected fraudulent use of the Medicaid program, methods for investigating fraud cases, and procedures for referring suspected fraud to law enforcement officials.

The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1980 further authorized 90-percent FFP for the establishment and operation of a Medicaid fraud control unit in each State. Each unit must be a single identifiable entity located outside the Medicaid agency (for example, in the Office of the State's Attorney General). Fraud control units are responsible for investigating and prosecuting (or referring for prosecution) violations of State Medicaid laws, reviewing complaints alleging abuse or neglect of patients, recovering overpayments, and investigating recipient fraud. Staff of such units must include attorneys, auditors, and investigators. To receive FFP at the 90-percent rate, the unit must be certified by the U.S. Department of Health and Human Services. At the end of 1983, 34 Medicaid fraud control units were certified.

Table 4.24

Enrolled and participating physicians and Medicaid-certified beds, by type of provider and jurisdiction: March 1983

Medicaid jurisdiction	Physicians		Certified beds							
					Skilled nursing facility		Intermediate care facility	Intermediate care facility for mentally retarded	SNF-ICF[1]	
	Enrolled	Participating	General hospital	Swing-beds	Medicaid certified	Dually certified			Medicaid certified	Dually certified
United States	412,995	191,137	798,746	3,076	142,038	327,803	542,320	109,825	100,290	233,294
Alabama	4,000	3,700	21,128	—	86	10,221	5,953	1,523	0	4,480
Alaska	796	—	1,113	6	0	242	27	132	0	64
Arkansas	4,797	3,598	522	0	10,155	291	10,042	1,473	0	0
California	55,960	25,679	93,198	—	16,052	84,161	2,088	464	0	2,690
Colorado	10,314	5,416	12,928	0	8,190	7,450	1,676	3,538	0	15,640
Connecticut	—	—	—	—	—	—	—	—	—	—
Delaware	—	—	—	—	—	—	—	—	—	—
District of Columbia	3,134	1,573	5,456	—	953	—	3,854	516	—	763
Florida	18,000	10,000	54,060	0	318	0	1,419	2,719	34,240	0
Georgia	12,917	7,092	25,098	0	22,707	26,714	5,753	2,683	0	32,467
Hawaii	—	—	—	—	—	—	—	—	—	—
Idaho	3,047	1,539	3,416	0	0	0	189	543	0	4,425
Illinois	18,513	—	57,500	—	0	194	36,443	4,272	0	47,415
Indiana	9,595	5,040	24,063	0	301	8,645	36,407	2,135	0	0
Iowa	5,512	3,967	20,596	0	47	438	29,490	1,902	0	79
Kansas	—	—	—	—	—	—	—	—	—	—
Kentucky	12,298	5,149	17,939	8	0	3,823	14,236	1,283	0	30
Louisiana	6,810	3,220	19,972	0	1,681	1,681	24,072	6,221	1,681	1,681
Maine	3,110	1,586	4,960	0	0	404	8,769	662	0	0
Maryland	—	4,393	22,264	0	0	9,926	10,899	2,834	0	389
Massachusetts	13,110	—	27,247	0	13,024	5,715	27,696	4,051	0	0
Michigan	14,836	—	[2] 40,169	0	11,285	17,978	8,893	4,525	0	7,396
Minnesota	—	—	—	—	—	—	—	—	—	—
Mississippi	[3] 7,483	[3] 2,503	13,003	40	1,954	0	1,546	1,503	9,769	595
Missouri	10,048	2,800	29,631	265	0	178	12,700	1,789	8,839	5,833
Montana	—	—	—	—	—	—	—	—	—	—

See footnotes at end of table.

Table 4.24—Continued

Enrolled and participating physicians and Medicaid-certified beds, by type of provider and jurisdiction: March 1983

Medicaid jurisdiction	Physicians		Certified beds							
					Skilled nursing facility		Intermediate care facility	Intermediate care facility for mentally retarded	SNF-ICF[1]	
	Enrolled	Participating	General hospital	Swing-beds	Medicaid certified	Dually certified			Medicaid certified	Dually certified
Nebraska	5,100	4,050	8,366	80	2,134	575	15,320	1,040	0	—
Nevada	3,179	1,568	3,633	0	0	0	340	291	0	2,036
New Hampshire	1,122	1,089	3,198	5	0	566	6,190	340	0	0
New Jersey	29,249	9,196	33,003	0	0	86	3,104	3,988	9,220	18,017
New Mexico	3,089	1,213	4,105	—	0	279	3,530	632	0	—
New York	29,934	27,076	78,021	0	193	71,611	25,147	17,917	0	0
North Carolina	6,800	2,559	28,285	0	0	9,397	11,145	2,687	0	0
North Dakota	1,920	601	3,878	398	4,353	2,867	2,404	348	0	4,353
Ohio	14,401	—	—	0	0	413	27,207	6,712	0	42,235
Oklahoma	[3] 17,500	—	1,923	0	0	415	28,612	2,197	0	239
Oregon	4,284	4,284	10,023	332	8,018	3,628	8,224	2,034	0	4,875
Pennsylvania	16,692	12,815	62,706	0	23,930	32,847	15,718	8,835	0	—
Rhode Island	1,355	1,355	3,462	0	2,266	2,266	6,337	1,021	0	0
South Carolina	5,115	3,530	12,758	0	152	7,150	4,007	2,638	0	7,150
South Dakota	—	—	—	—	—	—	—	—	—	—
Tennessee	4,359	2,561	—	1,927	3,194	1,927	24,637	2,455	1,927	1,927
Texas	24,439	12,525	—	—	11,045	1,873	83,603	3,944	0	—
Utah	3,652	2,931	4,876	—	0	0	2,861	350	0	2,233
Vermont	1,200	800	—	—	—	—	—	—	—	—
Virginia	7,269	6,283	23,795	0	0	1,804	22,565	882	0	0
Washington	4,804	3,572	—	15	0	11,534	1,461	2,993	0	11,619
West Virginia	3,657	2,430	—	0	0	0	3,769	167	0	3,518
Wisconsin	9,595	3,444	24,510	0	0	504	3,987	3,586	34,614	11,145
Wyoming	—	—	—	—	—	—	—	—	—	—

[1] SNF = skilled nursing facility; ICF = intermediate care facility.
[2] Not swing-beds but general hospital based on long-term care beds.
[3] Includes out-of-State physicians.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy, and LaJolla Management Corporation: *Analysis of State Medicaid Program Characteristics.* Rockville, Md., 1983.

Table 4.25

Medicaid Supplemental Security Income eligibility determination and status of Medicaid Management Information System, by jurisdiction: March 1983

Medicaid jurisdiction	Supplemental Security Income eligibility determination[1]			Medicaid Management Information System			
	Section 1634	State determination	209(b) State	Certified	Certification anticipated fiscal year 1984	Certification implementation plan	None
Alabama	x			x			
Alaska		x					x
Arkansas	x			x			
California	x			x			
Colorado	x			x			
Connecticut			x			x	
Delaware	x						x
District of Columbia	x			x			
Florida	x			x			
Georgia	x			x			
Hawaii			x	x			
Idaho		x		x			
Illinois			x		x		
Indiana			x	x			
Iowa	x			x			
Kansas		x		x			
Kentucky	x				x	x	
Louisiana	x			x			
Maine	x			x			
Maryland	x				x		
Massachusetts	x					x	
Michigan	x				x		
Minnesota			x	x			
Mississippi	x			x			
Missouri			x	x			
Montana	x			x			
Nebraska			x	x			
Nevada		x					x
New Hampshire			x	x			
New Jersey	x			x			
New Mexico	x			x			
New York	x			x			
North Carolina			x	x			
North Dakota			x	x			
Ohio			x	x			
Oklahoma			x	x			
Oregon		x		x			
Pennsylvania	x			x			
Rhode Island	x						x
South Carolina	x			x			
South Dakota	x						
Tennessee	x			x			
Texas	x			x			
Utah			x	x			
Vermont	x			x			
Virginia			x	x			
Washington	x			x			
West Virginia	x			x			
Wisconsin	x			x			
Wyoming	x						x

[1] Eligibility determination for the territories is based on separate regulations and is found in 42 Code of Federal Regulations 436. The Medicaid agency may not require a separate application for Medicaid from an individual if the individual receives cash assistance under a State plan for Old Age Assistance, Aid to Families With Dependent Children, Aid to the Blind, Aid to the Permanently and Totally Disabled, or Aid to the Aged, Blind, and Disabled.

SOURCES: Health Care Financing Administration, Office of Eligibility Policy and Office of Methods and Systems: Unpublished data.

National Medical Care Utilization and Expenditure Survey

In the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES), national health data were collected from a sample of the U.S. civilian noninstitutionalized population. Data from NMCUES can be used to make detailed comparisons of selected population groups and their use of health services by insurance coverage, sociodemographic characteristics, and health status. Data on the use of health care services by Medicaid and non-Medicaid populations in the United States are presented by type of service, ethnicity, and race.

A comparison of unadjusted use rates per 1,000 person-years for Medicaid and non-Medicaid populations is shown by ethnicity and race in Table 4.26 for the following types of service: hospital discharges, hospital days of care, physician visits, emergency room visits, outpatient visits, and dental visits (O'Brien, Rodgers, and Baugh). Medicaid use rates were significantly higher than non-Medicaid use rates for all services except for dental visits, for which the Medicaid rate was significantly lower (882 compared with 1,262). Black Medicaid enrollees had significantly lower use rates than white enrollees for each service except outpatient visits.

Because significant sociodemographic differences exist among ethnic and racial groups, these rates were adjusted to remove the influence of demographic and health status factors (including health status, functional limitation, sex, age, and education). Table 4.27 summarizes statistically significant differences in the unadjusted and adjusted use rates of the Medicaid and non-Medicaid populations. The differences were dramatic. After adjustment, the hospital discharge rate was the only service for which black enrollees had significantly lower use rates than white enrollees. For each of the other rates—hospital days of care, physician visits, emergency room visits, and dental visits—the differences between black and white enrollees were no longer significant. However, the adjusted outpatient visit rate for white enrollees became significantly lower than that for black enrollees.

No consistent pattern of differences in the adjusted rates of Hispanic Medicaid enrollees and either white or black enrollees can be seen. There was only one significant difference in adjusted rates by type of service. Hispanic enrollees had a significantly lower outpatient visit rate than black enrollees had.

Significant differences in adjusted use rates for the non-Medicaid population are also presented in Table 4.27. Within this population, Hispanic persons had a lower physician visit rate than white persons, a lower emergency room visit rate than either white or black persons, and a lower outpatient visit rate than black persons. Use of dental services was lowest for black persons.

In summary, unadjusted use rates for black Medicaid enrollees were relatively low for all types of services except outpatient visits. After rate adjustment, only one significant difference remained: Black Medicaid enrollees had lower hospital discharge rates than white enrollees had.[10] Although there were no unadjusted rate differences for outpatient visits, black Medicaid enrollees had higher adjusted outpatient visit rates than either white or Hispanic enrollees. Despite adjusting for demographic and health status factors, no adequate explanation of these differences was found. This study shows that adjusted use rates are needed to compare different ethnic and racial groups.

Table 4.26

Unadjusted health care use rates for noninstitutionalized persons, by race and ethnic origin, type of service, and Medicaid status: United States, calendar year 1980

Type of service and Medicaid status	Race and ethnic origin			
			Not Hispanic	
	Total[1]	Hispanic	White	Black
	Rate per 1,000 person-years			
Hospital discharges				
Medicaid	332	304	400	224
Non-Medicaid	158	129	161	155
Hospital days of care				
Medicaid	2,503	[2]2,055	3,043	1,864
Non-Medicaid	1,150	681	1,186	1,247
Physician visits				
Medicaid	5,605	5,054	6,593	4,275
Non-Medicaid	3,960	2,878	4,101	3,538
Emergency room visits				
Medicaid	519	476	598	429
Non-Medicaid	250	197	246	318
Outpatient visits				
Medicaid	872	[2]684	871	998
Non-Medicaid	550	454	507	959
Dental visits				
Medicaid	882	927	1,014	609
Non-Medicaid	1,262	876	1,355	691

[1] Includes ethnic and racial groups other than Hispanic, white, or black.
[2] Relative standard error exceeds 25 percent.

SOURCE: O'Brien, M.K., Rodgers, J., and Baugh, D.: Ethnic and racial patterns in enrollment, health status, and health services utilization in the Medicaid population. *National Medical Care Utilization and Expenditure Survey.* Series B, Descriptive Report No. 8. To be published.

Medicaid data system

The majority of Medicaid data presented in this report came from a compilation of annual and monthly Medicaid reports (HCFA-2082 and HCFA-120 reports) submitted to HCFA by the State Title XIX Medicaid agencies. States obtain this information from their own Medicaid claims processing and payment operations.

The major claims processing and payment system used in the States is the Medicaid Management Information System. The General System Design for State sys-

[10] The findings of this study support earlier observations that differences in acute hospital use between black and white persons do exist (Link, Long, and Settle, 1982; Ruther and Dobson, 1981).

Table 4.27

Summary of statistically significant differences in unadjusted and adjusted use rates in the Medicaid and non-Medicaid populations: United States, calendar year 1980

Population and type of service	Unadjusted	Adjusted
Medicaid population	Rate	
Hospital discharges	B<W	B<W
Hospital days of care	B<W	NS
Physician visits	B<W, H<W	NS
Emergency room visits	B<W	NS
Outpatient visits	NS	W<B, H<B
Dental visits	B<W	NS
Non-Medicaid population		
Hospital discharges	NS	NS
Hospital days of care	B<H<W	NS
Physician visits	H<W	H<W
Emergency room visits	H<W<B	H<W<B
Outpatient visits	H<B, W<B	H<B, W<B
Dental visits	H<W, B<W	B<H, B<W

NOTE: H = Hispanic, W = white, B = black, < = less than, NS = No differences were statistically significant.

SOURCE: O'Brien, M.K., Rodgers, J., and Baugh, D.: Ethnic and racial patterns in enrollment, health status, and health services utilization in the Medicaid population. *National Medical Care Utilization and Expenditure Survey.* Series B, Descriptive Report No. 8. To be published.

tems, completed and distributed in 1972, allows for considerable variation in certain characteristics of MMIS. This flexibility is congruent with the program diversity existing among the States.

Creating standardized reports for systems employing nonstandard coding, processing, and file structures is obviously difficult. Compounding these difficulties are the differences within State programs. For example, the variation among counties inherent in the New York State program leads to considerable problems in the creation of a State-level report. As a consequence of these and other factors, approximately six States do not file an annual report in any fiscal year. In any month, approximately two States do not file a monthly report. Historically, these missing reports have been estimated by using weighted linear extrapolation methods and aggregating data from other reports. On several occasions, information supplied by the States in subsequent years has been used to refine or correct previous missing years of data. Hence, data contained in this report may differ from those published previously.

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Appendix A
Medicare carriers and intermediaries

Blue Cross Association

Blue Cross and Blue Shield Association
676 North St. Clair Street
Chicago, Illinois 60611

Blue Cross Plans

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Alaska—See Blue Cross of Washington and Alaska

Blue Cross and Blue Shield of Arizona, Inc.
2444 W. Las Palmaritas Drive
Phoenix, Arizona 85021
Mailing address:
P.O. Box 13466
Phoenix, Arizona 85002

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91470
Mailing address:
P.O. Box 70000
Van Nuys, California 91470

Rocky Mountain Hospital and Medical Service
(d.b.a. Blue Cross and Blue Shield of Colorado)
700 Broadway
Denver, Colorado 80273

Blue Cross and Blue Shield of Connecticut, Inc.
370 Bassett Road
North Haven, Connecticut 06473

Blue Cross and Blue Shield of Delaware, Inc.
One Brandywine Gateway
P.O. Box 1991
Wilmington, Delaware 19899

Group Hospitalization and Medical Services, Inc.
(d.b.a. Blue Cross and Blue Shield of the National Capital Area)
550 Twelfth Street, SW.
Washington, D.C. 20024

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2711
Jacksonville, Florida 32201

Blue Cross and Blue Shield of Georgia, Inc.
2357 Warm Springs Road
P.O. Box 7368
Columbus, Georgia 31908

Blue Cross of Idaho Health Service, Inc.
1501 Federal Way
P.O. Box 7408
Boise, Idaho 83707

Health Care Service Corp.
233 North Michigan Avenue
Chicago, Illinois 60601

Mutual Hospital Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Blue Cross of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Cross of Western Iowa and South Dakota
Hamilton Blvd. and I-29
Sioux City, Iowa 51102

Blue Cross and Blue Shield of Kansas, Inc.
1133 Topeka Boulevard
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40223

Louisiana Health Service and Indemnity Company
(d.b.a. Blue Cross of Louisiana)
5527 Reitz Avenue
Baton Rouge, Louisiana 70820-7006

Associated Hospital Service of Maine
(d.b.a Main Blue Cross and Blue Shield)
110 Free Street
Portland, Maine 04101

Blue Cross and Blue Shield of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Cross of Massachusetts
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Cross and Blue Shield of Mississippi, Inc.
P.O. Box 1043
Jackson, Mississippi 39216

Blue Cross Hospital Service, Inc. of Missouri
4444 Forest Park
St. Louis, Missouri 63108

Blue Cross of Montana
3360 10th Avenue, South
P.O. Box 5017
Great Falls, Montana 59403

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Main Post Office Station
Omaha, Nebraska 68180

New Hampshire-Vermont Health Service
Two Pillsbury Street
Concord, New Hampshire 03301

NOTE: d.b.a. means "doing business as."

Hospital Service Plan
of New Jersey
33 Washington Street
Newark, New Jersey 07102

New Mexico Blue Cross
and Blue Shield, Inc.
12800 Indian School Road, NE.
Albuquerque, New Mexico 87112

Blue Cross and Blue Shield
of Greater New York
622 Third Avenue
New York, New York 10017

Blue Cross and Blue Shield
of North Carolina
P.O. Box 2291
Durham, North Carolina 27702

Blue Cross of North Dakota
4510 13th Avenue, SW.
Fargo, North Dakota 58121

Community Mutual Insurance
Company
1351 William Howard Taft Road
Cincinnati, Ohio 45206
Mailing Address:
P.O. Box 14189
Cincinnati, Ohio 45214

Group Health Service
of Oklahoma, Inc.
1215 South Boulder Avenue
Tulsa, Oklahoma 74119

Blue Cross and Blue Shield
of Oregon
100 S.W. Market Street
P.O. Box 1271
Portland, Oregon 97201

Blue Cross of
Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Blue Cross and Blue Shield
of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield
of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

South Dakota - See Blue Cross
of Western Iowa and South Dakota

Blue Cross and Blue Shield
of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402

Blue Cross and Blue Shield
of Texas, Inc.
901 South Central Expressway
P.O. Box 833815
Richardson, Texas 75083-3815

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270 - Medicare A
Salt Lake City, Utah 84130

Blue Cross and Blue Shield
of Virginia
2015 Staples Mill Road
P.O. Box 27401
Richmond, Virginia 23279

Blue Cross of Washington
and Alaska
7001-220th, SW.
P.O. Box 327
Mountlake Terrace, Washington 98043

Blue Cross and Blue Shield
of West Virginia, Inc.
P.O. Box 231
Charleston, West Virginia 25325

Blue Cross and Blue Shield United
of Wisconsin
401 West Michigan Street
Milwaukee, Wisconsin 53201

Blue Cross and Blue Shield
of Wyoming
4000 House Avenue
P.O. Box 2266
Cheyenne, Wyoming 82001

Blue Shield Plans

Blue Cross and Blue Shield
of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35298

Arkansas Blue Cross and
Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

California Physicians Service
(d.b.a. Blue Shield of California)
No. 2 Northpoint
San Francisco, California 94120
Mailing address:
P.O. Box 7013
San Francisco, California 94120

Rocky Mountain Hospital and
Medical Service
(d.b.a. Blue Cross and Blue
Shield of Colorado)
700 Broadway
Denver, Colorado 80273

Delaware—See Pennsylvania
Blue Shield

District of Columbia—See
Pennsylvania Blue Shield

Blue Cross and Blue Shield of
Florida, Inc.
P.O. Box 1798
Jacksonville, Florida 32201

Health Care Service Corporation
233 North Michigan Avenue
Chicago, Illinois 60601

Mutual Medical Insurance, Inc.
Medicare Department
120 West Market Street
Indianapolis, Indiana 46204

Blue Shield of Iowa
636 Grand Avenue, Station 28
Des Moines, Iowa 50307

Blue Cross and Blue Shield of
Kansas, Inc.
P.O. Box 239
1133 Topeka Blvd.
Topeka, Kansas 66601

Blue Cross and Blue Shield
of Kentucky, Inc.
1218 Harrodsburg Road
Lexington, Kentucky 40504

Louisiana—See Arkansas Blue
Cross and Blue Shield, Inc.

Maine—See Blue Shield of
Massachusetts, Inc.

Blue Cross and Blue Shield
of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Shield of
Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02110

Blue Cross and Blue Shield
of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield
of Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Cross and Blue Shield
of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Montana Physicians' Service
P.O. Box 4310
404 Fuller Avenue
Helena, Montana 59601

Nebraska—See Blue Shield
of Iowa

New Hampshire-Vermont
Health Services
Two Pillsbury Street
Concord, New Hampshire 03301

Blue Shield of
Western New York, Inc.
298 Maine Street
Buffalo, New York 14202

Blue Cross & Blue Shield of
Greater New York
622 Third Avenue
New York, New York 10017

Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121

Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, Pennsylvania 17011

Seguros de Servicio de Salud
de Puerto Rico, Inc.
GPO Box 3628
San Juan, Puerto Rico 00936

Blue Cross and Blue Shield
of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of
South Carolina
Columbia, South Carolina 29260

South Dakota—See Blue Shield
of North Dakota

Blue Cross and Blue Shield
of Texas, Inc.
901 South Central Expressway
P.O. Box 833815
Richardson, Texas 75083-3815

Blue Cross and Blue Shield of Utah
2455 Parley's Way
P.O. Box 30270 - Medicare B
Salt Lake City, Utah 84130

Vermont—See New Hampshire-
Vermont Health Service

Washington Physicians Service
4th and Battery Building
6th Floor
2401 4th Avenue
Seattle, Washington 98121

Wisconsin Physicians' Service
Insurance Corporation
1717 West Broadway
Madison, Wisconsin 53713
Mailing addresses:
P.O. Box 1787
Madison, Wisconsin 53701
P.O. Box 9277
Madison, Wisconsin 57315

Commercial, Independent, State, and Other

Aetna Life & Casualty Company
151 Farmington Avenue
Hartford, Connecticut 06156

Connecticut General Life
Insurance Company
900 Cottage Grove Road
Bloomfield, Connecticut 06002
Mailing address:
Hartford, Connecticut 06152

Cooperativa de Seguros de Vida
de Puerto Rico
GPO Box 3428
San Juan, Puerto Rico 00936

The Equitable Life Assurance
Society of the United States
1285 Avenue of the Americas
New York, New York 10019

General American Life Insurance
Company
13045 Tesson Ferry Road
St. Louis County, Missouri 63128

Group Health, Inc.
330 West 42nd Street
New York, New York 10036

Hawaii Medical Service Association
818 Keeaumoku
P.O. Box 860
Honolulu, Hawaii 96808

Mutual of Omaha Insurance Company
P.O. Box 456
Downtown Station
Omaha, Nebraska 68101

Nationwide Mutual Insurance
Company
P.O. Box 57
Columbus, Ohio 43216

The Prudential Insurance
Company of America
Tri-City Office, Drawer 471
Millville, New Jersey 08332

Transamerica Occidental Life
Insurance Company
12th at Hill Street
Los Angeles, California 90054
Mailing address:
P.O. Box 54905
Terminal Annex
Los Angeles, California 90054

The Travelers Insurance
Company
One Tower Square
Hartford, Connecticut 06115

Railroad Retirement Board
844 Rush Street
Chicago, Illinois 60611

Appendix B
Medicaid agencies and fiscal agents—single State agencies and State medical assistance units

Alabama (Region IV)—
Single State agency and
Medical assistance unit:
Alabama Medicaid Agency
2500 Fairlane Drive
Montgomery, Alabama 36130
205 277-2710

Alaska (Region X):
Single State agency:
Department of Health and Social Services
Pouch H-01
Juneau, Alaska 99811
907 465-3030

Medical assistance unit:
Division of Public Assistance
Department of Health and Social Services
Pouch H-07
Juneau, Alaska 99811
907 465-3355

Arizona (Section 1115 Demonstration Project)
Medical assistance unit:
Arizona Health Care Cost Containment System
P.O. Box 33069
Phoenix, Arizona 85013
602 234-3655

Arkansas (Region VI):
Single State agency:
Department of Human Services
Seventh and Main Streets
Donaghey Building, 13th Floor
Little Rock, Arkansas 72201
501 371-1001

Medical assistance unit:
Division of Social Services
Department of Human Services
P.O. Box 1437
Little Rock, Arkansas 72203
501 371-1806

California (Region IX):
Single State agency:
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 445-1248

Medical assistance unit:
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814
916 322-5824

Colorado (Region VII):
Single State agency:
Department of Social Services
1575 Sherman Street, Room 623
Denver, Colorado 80203
303 866-3041

Medical assistance unit:
Department of Social Services
1575 Sherman Street, Room 619
Denver, Colorado 80203
303 866-5111

Connecticut (Region I):
Single State agency:
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2008

Medical assistance unit:
Medical Care Administration
Dept. of Income Maintenance
110 Bartholomew Avenue
Hartford, Connecticut 06106
203 566-2934

Delaware (Region III):
Single State agency:
Department of Health and Social Services
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421-6705

Medical assistance unit:
Medical Assistance Services
Department of Health and Social Services
Biggs Building
Delaware State Hospital
P.O. Box 906
New Castle, Delaware 19720
302 421-6139

District of Columbia (Region III):
Single State agency:
Dept. of Human Services
801 North Capital Street
Room 700
Washington, D.C. 20002
202 727-0310

Medical assistance unit:
Office of Health Care Financing
Department of Human Services
1331 H Street, N.W., Room 500
Washington, D.C. 20005
202 727-0735

Florida (Region IV):
Single State agency:
Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Florida 32301
904 488-7721

Medical assistance unit:
Department of Health and Rehabilitative Services
1317 Winewood Boulevard
Building 6, Room 233
Tallahassee, Florida 32301
904 488-3560

Georgia (Region IV):
Single State agency and medical assistance unit:
Georgia Department of Medical Assistance
Twin Towers Office Building
Room 1220-C, West Tower
2 Martin Luther King Drive
Atlanta, Georgia 30334
404 656-4479

Guam (Region IX):
Single State agency and medical assistance unit:
Department of Public Health and Social Services
P.O. Box 2816
Agana, Guam 96910

Hawaii (Region IX):
Single State agency:
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6260

Medical assistance unit:
Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
808 548-6584

Idaho (Region X):
Single State agency:
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-4079

Medical assistance unit:
Bureau of Medical Assistance
Department of Health and Welfare
Statehouse
Boise, Idaho 83720
208 334-4326

Illinois (Region V):
Single State agency:
Illinois Dept. of Public Aid
316 South Second Street
Springfield, Illinois 62762
217 782-6716

Medical assistance unit:
Illinois Dept. of Public Aid
628 E. Adams Street
Springfield, Illinois 62701
217 782-2550

Indiana (Region V):
Single State agency:
Indiana Dept. of Public Welfare
State Office Building
100 North Senate Ave., Room 701
Indianapolis, Indiana 46204
317 232-4705

Medical assistance unit:
Indiana Department of Public Welfare
State Office Building
100 North Senate Ave., Room 701
Indianapolis, Indiana 46204
317 232-4324

Iowa (Region VII):
Single State agency:
Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, Iowa 50319
515 281-5452

Medical assistance unit:
Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, Iowa 50319
515 281-8621

Kansas (Region VII):
Single State agency:
Dept. of Social and Rehabilitation Services
State Office Bldg., 6th Floor
Topeka, Kansas 66612
913 296-3271

Medical assistance unit:
Dept. of Social and Rehabilitation Services
State Office Bldg., 6th Floor
Topeka, Kansas 66612
913 296-3981

Kentucky (Region IV):
Single State agency:
Dept. of Social Insurance
CHR Building
275 East Main Street
Frankfort, Kentucky 40621
502 564-3703

Medical assistance unit:
Dept. of Social Insurance
CHR Building
275 East Main Street
Frankfort, Kentucky 40621
502 564-4321

Louisiana (Region VI):
Single State agency:
Dept. of Health and Human Resources
P.O. Box 3776
Baton Rouge, Louisiana 70821
504 342-6711

Medical assistance unit:
Dept. of Health and Human Resources
P.O. Box 44065
Baton Rouge, Louisiana 70804
504 342-3956

Maine (Region I):
Single State agency:
Dept. of Human Services
221 State Street
Statehouse, Station II
Augusta, Maine 04333
207 289-2736

Medical assistance unit:
Dept. of Human Services
Whitten Road
Statehouse, Station II
Augusta, Maine 04333
207 289-2716

Maryland (Region III):
Single State agency:
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201
301 383-2600

Medical assistance unit:
Dept. of Health and Mental Hygiene
201 West Preston Street, Room 524
Baltimore, Maryland 21201
301 383-6327

Massachusetts (Region I):
Single State agency:
Department of Public Welfare
600 Washington Street, Room 501
Boston, Massachusetts 02111
617 727-6190

Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5580

Medical assistance unit:
Department of Public Welfare
600 Washington Street
Boston, Massachusetts 02111
617 727-7958

Medical assistance:
Massachusetts Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
617 727-5550

Michigan (Region V):
Single State agency:
Michigan Department of Social Services
P.O. Box 30037
Lansing, Michigan 48909
517 373-2000

Medical assistance unit:
Department of Social Services
P.O. Box 30037
Lansing, Michigan 48910
517 373-9440

Minnesota (Region V):
Single State agency:
Minnesota Department of Public Welfare
Centennial Office Building
658 Cedar Street
Saint Paul, Minnesota 55155
612 296-2701

Medical assistance unit:
Bureau of Income Maintenance
Dept. of Public Welfare
Space Center Bldg., 1st Floor
444 Lafayette Road
Saint Paul, Minnesota 55101
612 296-2766

Mississippi (Region IV):
Single State agency and medical assistance unit:
Mississippi Medicaid Commission
4785 I-55 North
P.O. Box 16786
Jackson, Mississippi 39236
601 981-4507

Missouri (Region VII):
Single State agency:
Department of Social Services
Broadway State Office Building
Jefferson City, Missouri 65102
314 751-4815

Medical assistance unit:
Division of Family Services
Medical Services Section
P.O. Box 88
Broadway State Office Building
Jefferson City, Missouri 65103
314 751-3425

Montana (Region VII):
Single State agency:
Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-5622

Medical assistance unit:
Economic Assistance Division
Department of Social and Rehabilitative Services
P.O. Box 4210
Helena, Montana 59604
406 444-4540

Nebraska (Region VII):
Single State agency and medical assistance unit:
Department of Social Services
301 Centennial Mall South
5th Floor
Lincoln, Nebraska 68509
402 471-3121

Nevada (Region IX):
Single State agency:
Department of Human Resources
Kinkead Building-Capitol Complex
505 East King Street
Carson City, Nevada 89710
702 885-4730

Medical assistance unit:
Medical Care Section (Title XIX)
Department of Human Resources
251 Jeanell Drive
Capitol Complex
Carson City, Nevada 89710
702 885-4698

New Hampshire (Region I):
Single State agency:
Department of Health and Welfare
State Office Park East
Hazen Drive
Concord, New Hampshire 03301
603 271-4321

Medical assistance unit:
Office of Medical Services
Division of Health and Human Services
Hazen Drive
Concord, New Hampshire 03301
603 271-4353

New Jersey (Region II):
Single State agency:
Department of Human Services
Capitol Place One
222 South Warren St.
Trenton, New Jersey 08625
609 292-3717

Medical assistance unit:
Division of Medical Assistance and Health Services
Department of Human Services
Building No. 7
Quakerbridge Plaza, CN 712
Trenton, New Jersey 08625
609 292-7244

New Mexico (Region VI):
Single State agency:
Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-4072

Medical assistance unit:
Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87503
505 827-4315

New York (Region II):
Single State agency:
State Dept. of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243
518 474-9475

Medical assistance unit:
Division of Medical Assistance
State Dept. of Social Services
40 North Pearl Street
Albany, New York 12243
518 474-9132

North Carolina (Region IV):
Single State agency:
Dept. of Human Resources
325 North Salisbury Street
Raleigh, North Carolina 27611
919 733-4534

Medical assistance unit:
Division of Medical Assistance
Dept. of Human Resouces
1985 Umstead Drive
Raleigh, North Carolina 27603
919 733-2060

North Dakota (Region VIII):
Single State agency:
Department of Human Services
State Capitol Building
Bismarck, North Dakota 58505
701 224-2310

Ohio (Region V):
Single State agency:
Ohio Dept. of Human Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43215
614 466-6282

Medical assistance unit:
Ohio Dept. of Human Services
30 East Broad Street, 31st Floor
Columbus, Ohio 43215
614 466-6024

Oklahoma (Region VI):
Single State agency:
Dept. of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3646

Medical assistance unit:
Medical Services Division
Dept. of Human Services
P.O. Box 25352
Oklahoma City, Oklahoma 73125
405 521-3801

Oregon (Region X):
Single State agency:
Dept. of Human Resources
318 Public Service Building
Salem, Oregon 97310
503 378-3034

Medical assistance unit:
Adult and Family Services Division
Dept. of Human Resources
203 Public Service Building
Salem, Oregon, 97310
503 378-2263

Pennsylvania (Region III):
Single State agency:
State Dept. of Public Welfare
Health and Welfare Building, Room 333
Harrisburg, Pennsylvania 17120
717 787-2600

Medical assistance unit:
State Dept. of Public Welfare
Health and Welfare Bldg., Room 515
Harrisburg, Pennsylvania 17120
717 787-1870

Puerto Rico (Region II):
Single State agency:
Department of Health
P.O. Box 9342
Santurce, Puerto Rico 00908
809 751-8259

Medical assistance unit:
Health Economy Office
Department of Health
Building A
Call Box 70184
San Juan, Puerto Rico 00936
809 765-9941

Rhode Island (Region I):
Single State agency:
Dept. of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-2121

Medical assistance unit:
Dept. of Social and Rehabilitative Services
Aime J. Forand Building
600 New London Avenue
Cranston, Rhode Island 02920
401 464-3575

South Carolina (Region IV):
Single State agency:
State Health and Human Services
P.O. Box 8206
Columbus, South Carolina 29202-8206
803-758-3175

Medical assistance unit:
Office of Health Care Financing
State Health and Human Services
P.O. Box 8206
Columbus, South Carolina 29202-8206
803 758 8693

South Dakota (Region VIII):
Single State agency:
Dept. of Social Services
Kneip Building
700 North Illinois
Pierre, South Dakota 57501
605 773-3165

Medical assistance unit:
Office of Medical Services
Dept. of Social Services
Kneip Building
700 North Illinois
Pierre, South Dakota 57501
605 773-3495

Tennessee (Region IV):
Single State agency:
Dept. of Health and Environment
344 Cordell Hull Building
Nashville, Tennessee 37219
615 741-3111

Medical assistance unit:
Bureau of Medicaid
Department of Health and Environment
729 Church Street
Nashville, Tennessee 37219
615 741-0213

Texas (Region VI):
Single State agency:
Texas Dept. of Human Resources
Banister Lane Bldg.
P.O. Box 2960
Austin, Texas 78769
512 450-3030

Medical assistance unit:
Texas Dept. of Human Resources
Banister Lane Bldg.
P.O. Box 2960
Mail Code 500-4
Austin, Texas 78769
512 450-3020

Utah (Region VIII):
Single State agency:
Utah State Dept. of Health
P.O. Box 45500
Salt Lake City, Utah 84145-0500
801 533-6111

Medical assistance unit:
Division of Health Care Financing
P.O. Box 45500
Salt Lake City, Utah 84145-0500
801 533-6151

Vermont (Region I):
Single State agency:
Dept. of Social Welfare
103 South Main Stret
Waterbury, Vermont 05676
802 241-2853

Medical assistance unit:
Dept. of Social Welfare
103 South Main Street
Waterbury, Vermont 05676
802 241-2880

Virgin Islands (Region II):
Single State agency:
Dept. of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-0117

Medical assistance unit:
Bureau of Health Insurance and Medical Assistance
Dept. of Health
P.O. Box 7309
Charlotte Amalie
St. Thomas, Virgin Islands 00801
809 774-4624

Virginia (Region III):
Single State agency and medical assistance unit:
Dept. of Medical Assistance Services
109 Governor Street, Suite 800
Richmond, Virginia 23219
804 786-7933

Washington (Region X):
Single State agency and medical assistance unit:
Division of Medical Assistance
Dept. of Social and Health Services
Mail Stop HB-41
Olympia, Washinton 98504
206 753 1777

West Virginia (Region III):
Single State agency:
West Virginia Department of Human Services
1900 Washington Street, East, Room B-717
Charleston, West Virginia 25305
304 348-8990

Medical assistance unit:
Division of Medical Care
West Virginia Dept. of Human Services
1900 Washington Street, East
Charleston, West Virginia 25305
304 348-8990

Wisconsin (Region V):
Single State agency:
Wisconsin Dept. of Health and Social Services
One West Wilson Street, Room 663
P.O. Box 7850
Madison, Wisconsin 53707
608 266-3681

Medical assistance unit:
Bureau of Health Care Financing
Wisconsin Dept. of Health and Social Services
One West Wilson Street, Room 244
P.O. Box 309
Madison, Wisconsin 53701
608 266-2522

Wyoming (Region VIII):
Single State agency:
Dept. of Health and Social Services
317 Hathaway Building
Cheyenne, Wyoming 82002
307 777-7657

Medical assistance unit:
Medical Assistance Services
Dept. of Health and Social Services
317 Hathaway Building, Room 448
Cheyenne, Wyoming 82002
307 777-7531

Appendix C
Where to call for information

Medicare

Assignment of Medicare Claims
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Beneficiary Assistance on Claims and Entitlement
Office of Program Operations Procedures
Bureau of Program Operations (301)594-9545

Beneficiary Information
Office of Beneficiary Services (Baltimore) (301) 594-8131
Office of Beneficiary Service (D.C.) (202) 245-7684

Benefits Appeal Procedures
Office of Financial Operations
Bureau of Program Operations (301) 594-8431

Benefits Information
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9690

Conditions of Provider Participation
Office of Standards and Certification (301) 594-9690
Bureau of Eligibility, Reimbursement, and Coverage

Contractor Performance
Division of Performance Analysis
Bureau of Quality Control (301) 594-8000

Contracts
Division of Contracts
Office of Program Administration
Bureau of Program Operations (301) 594-9700

Cost Estimates
Division of Medicare Cost Estimates
Office of the Actuary (301) 594-2826

Deductibles: Explanation of Beneficiary Liability
Bureau of Program Policy (301) 594-9324

Enrollment Policy
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Entitlement
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Medicare Legislation
Medicare Branch (202) 245-2413

Medicare and Medicaid Fraud, Abuse and Waste
Health and Human Services (800) 638-3986 (MD. Toll Free)
Office of the Inspector General (800)368-5779 (Nationwide Free)

Peer Review Organizations (PRO's)
Office of Medical Review
Health Standards and Quality Bureau (301) 594-1432

Physician Provider Data
Analytical Studies Branch
Office of Research and Demonstrations, OR (301) 597-1460

Prevailing Charges Directory
Office of Program Administration
Bureau of Program Operations (301) 594-9470

Problems: Beneficiaries
Office of Beneficiary Services (301) 594-8131

Problems: General
Office of the Administrator
Office of Public Affairs (202) 245-6161

Procurements-Medicare
Division of Procurement
Office of Program Administration
Bureau of Program Operations (301) 594-8003

Public Information
Office of Public Affairs (D.C.) (202) 245-0923
Office of Public Affairs (Baltimore) (301) 597-3883

Publications: Office of Research and Demonstrations
ORD Publications Office (301) 597-2422

Publications: HCFA
Office of Public Affairs (301) 597-2618

Quality Control
Office of Quality Control Programs
Bureau of Quality Control (301) 597-1354

Quality Care Issues
Office of Medical Review
Health Standards and Quality Bureau (301) 594-1432

Reasonable Charges
Bureau of Eligiblity, Reimbursement, and Coverage (301) 597-1334

Reimbursement Methods
Division of Reimbursement and Economic Studies
Office of Research and Demonstrations (301) 594-8286

Reimbursement Policy
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9760

Regional Offices, HCFA
Boston (617) 223-6871
New York (212) 264-4488
Philadelphia (215) 596-1351
Atlanta (404) 221-2329
Chicago (312) 353-8057
Dallas (214) 767-6427
Kansas City (816) 374-5233
Denver (303) 837-2111
San Francisco (415) 556-0254
Seattle (206) 442-0425

Research and Demonstration Studies
Office of Research and Demonstrations (301) 597-3195

Rural Health Clinic Services
Division of Operational Initiatives
Office of Program Administration
Bureau of Program Operations (301) 594-9101

Service Coverage
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9690

State Certification Cost Data
Office of Standards and Certification
Health Standards and Quality Bureau (301) 597-5137

State and Contractor Standards
Office of Financial Operations
Bureau of Program Operations (301) 594-8431

State Buy-ins
Office of Program Operations Procedures
Bureau of Program Operations (301) 594-9545

Statistics: Assignment Rates
Division of Reports and Analysis
Bureau of Quality Control (301) 597-3440

Statistics: Beneficiaries
Division of Beneficiary Studies
Office of Research and Demonstrations (301) 597-1432

Statistics: Contractor Workloads and Cost
Division of Reports and Analysis
Bureau of Quality Control (301) 597-3440

Statistics: General
Division of Information Analysis
Bureau of Data Management and Strategy (301) 594-6705

Statistics: Institutional Care
Institutional Studies Branch
Office of Research and Demonstrations (301) 597-5710

Statistics: Non-institutional Studies
Noninstitutional Studies Branch
Office of Research and Demonstrations (301) 597-1416

Statistics: Peer Review Organizations
Office of Medical Review
Health Standards and Quality Bureau (301) 594-1432

Medicaid

Abortion Data
Division of Reports and Analysis
Bureau of Quality Control (301) 597-3440

Administration and Training Cost Data
Office of Financial Management and Administrative Systems
Office of Management and Budget (301) 597-6672

AFDC, Energy Assistance, Need, and Payment Standards
Office of Family Assistance
Office of Intergovernmental Communications (202) 245-2637

Beneficiary Information
Office of Beneficiary Services (Baltimore) (301) 597-2272

Eligibility
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9682

Eligibility Error Rates
Eligibility Assessment Branch
Division of Program Benefits Assessment
Bureau of Quality Control (301) 597-1384

EPSDT Data
Child Health and Prevention Staff
Executive Office
Bureau of Program Operations (301) 597-0451

Expenditures
Total Program Expenditure
Division of State Agency Financial Management
Bureau of Program Operations (301) 597-1702

Federal Financial Participation
Division of State Agency Financial Management
Office of Financial Operations
Bureau of Program Operations (301) 597-1389

Freedom of Choice Waivers
Office of Eligibility Policy (301) 594-8692
Bureau of Eligiblity, Reimbursement, and Coverage (301) 597-3870

Home and Community Based Waivers
Office of Coverage Policy
Bureau of Eligibility, Reimbursement, and Coverage (301) 594-9824

Medicaid Institutional Providers
Office of Statistics and Data Management
Bureau of Data Management and Strategy (301) 594-0942

Medicaid Legislation
Medicaid Branch (202) 245-8220

Medicaid Management Information Systems
Division of Medicaid Procedures
Office of Program Operations Procedures
Bureau of Program Operations (301) 594-8440

Medicaid Policy
Division of Policy Analysis
Office of Legislation and Policy (202) 472-5240

Medicaid Vendor Payments
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Medicare and Medicaid Fraud, Abuse and Waste
Health and Human Services (800) 638-3986 (MD. Toll Free)
Office of the Inspector General (800) 368-5779 (Nationwide Toll Free)

Medicare and Medicaid Regulations: Regulations Under Development and Status
Office of Regulations Management
Office of Executive Operations (301) 597-4462

Procurements - Medicaid
Division of Medicaid Procedures
Office of Program Operations Procedures
Bureau of Program Operations (301) 594-8440

Public Information
Office of Public Affairs (D.C.) (202) 245-6113
Office of Public Affairs (Baltimore) (301) 594-4323

Publications: Office of Research and Demonstrations
ORD Publications Office (301) 597-2422

Recipients
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Reference Services
Division of Congressional Affairs and Reference Services
Office of Legislation and Policy (202) 426-3717

Regional Offices, HCFA
Boston (617) 223-6871
New York (212) 264-4488
Philadelphia (215) 596-1351
Atlanta (404) 221-2329
Chicago (312) 353-8057
Dallas (214) 767-6427
Kansas City (816) 374-5233
Denver (303) 837-2111
San Francisco (415) 556-0254
Seattle (206) 442-0425

Research
Program Studies Branch (301) 597-1428
Office of Research and Demonstrations (301) 597-1454

State Assessment
Division of Performance Analysis
Bureau of Quality Control (301) 594-8000

State and Local Administration and Training
Office of Financial Management and Administrative Systems
Office of Management and Budget (301) 597-6672

State Certification Cost Data
Office of Standards and Certification
Health Standards Quality Bureau (301) 597-5137

State Data
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Statistics: General
Division of Medicaid Cost Estimates
Office of the Actuary (301) 597-1417

Supplemental Security Income
Social Security Administration
Division of Program Management and Analysis
Office of Supplemental Security Income (202) 673-5747

Third-Party Liability
Division of Operational Initiatives
Office of Program Administration (301) 594-9101
Bureau of Program Operations (301) 594-6703

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Appendix D
Glossary of Medicare and Medicaid terms

Aged—Medicaid eligibility is determined on the basis of financial need for people who meet Supplemental Security Income eligibility criteria (aged, blind, or disabled individuals) and Aid to Families With Dependent Children criteria (adults and children). Eligibility determinations are made for an entire economic unit or "case" (sometimes a family) based on whether or not one member of a case meets the criteria. For example, an "aged" case could consist of a 66-year-old male and his 63-year-old wife. In contract, a disabled enrollee could be over 65 years of age.

Assignment—An enrollee in the supplementary medical insurance program may agree with a provider of service to assign benefit rights to the provider. When this assignment method is used, the provider agrees to accept as the total charge for a covered service the amount that is approved by the carrier as the reasonable charge. The provider submits a claim to the carrier and is reimbursed for the reasonable charge minus 20-percent coinsurance and any unmet deductible. The provider may then charge the enrollee only for coinsurance and unmet deductible.

Automatic enrollment—Retirement and survivors insurance beneficiaries are automatically sent to Medicare cards 3 months before they attain age 65. Those entitled to disability benefits are automatically sent Medicare cards 3 months before the completion of 24 consecutive months of entitlement. These Medicare cards show entitlement to both hospital insurance and supplementary medical insurance (SMI). An enrollee wishing to decline SMI coverage must do so in writing no later than the month prior to the effective date of coverage.

Average compound rate of growth—Also called the average annual rate of change, this is a geometric rate of change in which a variable increases or decreases at the same rate each year. For example, an average annual rate of change of 10 percent, starting with a base of 100, would increase to 110 in the first year, 121 in the second year, and so on.

Benefit period—A benefit period is the period used to limit Medicare benefits in the hospital insurance program. A benefit period begins the first day an enrollee is furnished inpatient hospital or care (skilled nursing or rehabilitation) services by a qualified provider and ends when the enrollee has not been an inpatient for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Carrier—A carrier is an organization that has contracted with the Department of Health and Human Services to process claims and perform other services under Medicare's supplementary medical insurance program.

Case mix—The diagnosis-specific makeup of a hospital's patients, case-mix directly influences length of stay, intensity, cost, and scope of the services provided by a hospital.

Categorically needy—Under Medicaid, categorically needy cases are aged, blind, or disabled individuals or families and children who meet financial eligibility requirements for Aid to Families with Dependent Children, Supplemental Security Income, or an optional State supplement.

Coinsurance—Coinsurance is that portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not cover. Under hospital insurance (HI), there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st through the 90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of skilled nursing facility (SNF) care; from the 21st through the 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under supplementary medical insurance (SMI), after the annual deductible has been met, Medicare pays 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges is the coinsurance payable by the enrollee. However, there is no coinsurance for home health services under SMI.

Copayment—Copayment is a type of cost sharing under Medicaid. When copayment is used, insured or covered persons pay a specified flat amount per unit of service or unit of time, and the insurer pays the rest of the cost.

Covered services—Covered services are the services and supplies for which Medicare will reimburse. Examples of covered services are given in this glossary under specific headings, such as skilled nursing facility services. Covered services under the Medicaid program are a combination of mandatory and optional services that differs by State.

Customary charge—Customary charges are the amounts physicians or suppliers usually bill patients for furnishing particular services or supplies.

Deductible—Deductibles are the amounts paid by enrollees for covered services before Medicare makes reimbursements. The hospital insurance deductible, applied to each new benefit period, is determined each year by a formula specified by law and approximates the current cost of a 1-day inpatient hospital stay. The supplementary medical insurance deductible is, by law, the first $75 of covered charges per calendar year, effective January 1, 1982.

Diagnosis-related group—Diagnosis-related groups classify patients into groups that are clinically coherent and homogenous with respect to use of medical resources. This allows equitable payment across hospitals, in that comparable services can be comparably reimbursed.

Disabled—For purposes of enrollment under Medicare, individuals under 65 years of age who have been entitled to disability benefits under the Social Security Act or the railroad retirement system for at least 24 months are considered disabled and are entitled to Medicare.

Discharge—A discharge is a formal release from a hospital or skilled nursing facility. Discharges include persons who died during their stay or were transferred to another facility.

Early and periodic screening, diagnosis, and treatment (EPSDT)—The EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered.

End-stage renal disease (ESRD)—Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have ESRD. To qualify for Medicare coverage an individual with ESRD must be fully or currently insured under social security or the railroad retirement system, or be the dependent of an insured person. Eligibility for Medicare coverage begins with the third month after the beginning of a course of renal dialysis. Coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility or receives a kidney transplant without starting or receiving dialysis.

Enrollment period—Effective October 1, 1981, continuous open enrollment for Medicare supplementary medical insurance was repealed and the general enrollment period of January 1 through March 31 of each year reinstated. Coverage takes effect July 1.

Expenditure—Expenditure refers to an amount paid by a State agency for the covered medical expenses of eligible Medicaid participants. (For Medicare, see "reimbursement.")

Family planning services—Family planning services are any medically approved means furnished or prescribed by or under the supervision of a physician to individuals of childbearing age for purposes of enabling such individuals freely to determine the number or spacing of their children. Diagnosis, treatment, drugs, supplies and devices, and related counseling are included.

Federal hospital insurance trust fund—The Federal hospital insurance trust fund is a trust fund of the Treasury of the United States in which are deposited monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by social security. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program.

Federal supplementary medical insurance trust fund—The Federal supplementary medical insurance trust fund is a trust fund of the Treasury of the United States consisting of amounts deposited in or appropriated to the fund as provided by Title XVIII of the Social Security Act, including premiums paid by enrollees under supplementary medical insurance (SMI) and contributions by the Federal Government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Fiscal agent—A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. Under Medicare, fiscal agents are called intermediaries or hospital insurance and carriers for supplementary medical insurance.

Fiscal year—Fiscal years 1972 through 1976 extended from July 1 through June 30. Beginning with October 1, 1977, fiscal years extend from October 1 through September 30.

General hospital—A general hospital is a hospital maintained primarily for inpatient care of acute illness or injury and for obstetrics.

Group practice prepayment plan (GPPP)—In general, members of GPPP's pay regular premiums to the plan. In return, members receive the health services the plan provides without additional charge. Many prepayment plans have made arrangements with Medicare to receive direct payments for services they furnish that are covered by supplementary medical insurance.

Health insuring organization—A health insuring organization pays for medical services provided to recipients who pay a premium or subscription charge. The organization then assumes an underwriting risk with regard to expenses for the services provided.

Health maintenance organization (HMO)—Some group practice prepayment plans also provide many inpatient services and therefore have contracts with Medicare as HMO's. They receive direct payment for services covered by hospital insurance and supplementary medical insurance.

Home health agency—A home health agency is a public or private organization that provides skilled nursing services and other therapeutic services in patients' homes and that meets certain conditions to ensure the health and safety of the individuals furnished services.

Home health services—Home health services are services and items furnished in patients' homes under the care of physicians by home health agencies or by others under arrangements made by such agency. The services are furnished under a plan established and periodically reviewed by a physician. Services include part-time or intermittent skilled nursing care; physical, occupational, and speech therapy; medical social services; medical supplies and appliances (other than drugs and biologicals); home health aide services; and services of interns and residents.

Hospital insurance—Hospital insurance (also known as Medicare Part A) is a program providing basic protection against the costs of hospital and related posthospital services for individuals who are age 65 or over and are eligible for retirement benefits under the social security or railroad retirement systems; for individuals under age 65 who have been entitled to disability benefits under the social security or railroad retirement systems for at least 24 months and for certain other individuals who are medically determined to have end-stage renal disease and are covered by the social security or railroad retirement systems.

Independent laboratory—An independent laboratory is certified to perform diagnostic tests independent of a physician's office or hospital and receive reimbursements from Medicare.

Inpatient hospital services—Inpatient hospital services are items and services furnished to an inpatient by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Intermediary—An intermediary is an organization selected by providers of health care that has an agreement with the Department of Health and Human Services to process claims and perform other functions under Medicare's hospital insurance program.

Intermediate care facility—An intermediate care facility is an institution furnishing health-related care and services to individuals who do not require the degree of care provided by hospitals or skilled nursing facilities as defined under Title XIX (Medicaid) of the Social Security Act.

Laboratory and radiological services—These are professional and technical laboratory and radiological services ordered by a licensed practitioner and provided in an office or similar facility (other than a hospital outpatient department or clinic) or by a qualified laboratory.

Lifetime reserve—A Medicare hospital insurance enrollee has a nonrenewable lifetime reserve of 60 days of inpatient hospital care to draw on if the 90 covered days per benefit period are exhausted.

Long-stay hospital—A long-stay hospital is one in which the average patient stay is 30 days or more.

Medically needy—Under Medicaid, medically needy cases are aged, blind, or disabled individuals or families and children whose income and resources are above the financial eligibility requirements for categorical need but are within limits set under the Medicaid State plan.

Other practitioners' services—These are health care services of licensed practitioners other than physicians and dentists.

Outpatient hospital services—These are services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

Outpatient Services—These are medical and other services provided by a hospital or other qualified facility or supplier, such as a mental health clinic, rural health clinic, mobile X-ray unit, or freestanding dialysis unit. Outpatient services include outpatient physical therapy services, diagnostic X-ray and laboratory tests, X-ray and other radiation therapy.

Peer review organization—See Utilization and Quality Control Peer Review Organization.

Person served—Under Medicare, a person served is a Medicare enrollee who uses a covered medical service, incurs expenses greater than the deductible amount, and for whom Medicare pays benefits.

Physicians' services—Under Medicare and Medicaid, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Portable X-ray—A portable X-ray is a radiograph taken with portable equipment, usually in the patient's place of residence, under the general supervision of a physician.

Premium—A premium is a monthly fee paid by Medicare enrollees. Hospital insurance (HI) enrollees who are social security or railroad retirement beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain coverage. Supplementary medical insurance (SMI) enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

Premium hospital insurance—Persons 65 years of age or over who are not automatically eligible for hospital insurance may obtain coverage by paying a monthly premium.

Prescribed drugs—Prescribed drugs are drugs dispensed either by a licensed pharmacist on the prescription of a practitioner licensed by law to administer such drugs or by a licensed practitioner to his own patients. Drug charges that are not separable from a practitioner's other charges and drugs covered by a hospital bill are not included.

Prevailing charge—The prevailing charge is the charge at the 75th percentile in an array of the weighted customary charges made for similar services in the same locality. This is the upper limit of charges deemed "reasonable" for Medicare reimbursement.

Professional standards review organization (PSRO)—A PSRO is a physician or other professionl medical organization (consisting of physicians and other health professional with independent admitting hospital privileges) that enters into an agreement with the Department of Health and Human Services to assume the responsibility for Medicare, Medicaid, and the Maternal and Child Health program. PSRO's determine whether services are medically necessary, provided in accordance with professional standards, and, in the case of institutional services, rendered in the appropriate setting. See *Utilization and Quality Control Peer Review Organization.*

Psychiatric hospital—A psychiatric hospital is an institution primarily engaged inproviding to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mental illness.

Railroad retirement system—The railroad retirement system was mandated by the Railroad Retirement Act of 1937 as a retirement system for railroad employees.

Reasonable charge—In processing claims for supplementary medical insurance benefits, carriers use Health Care Financing Administration guidelines to establish the reasonable charge for services rendered. The reasonable charge is the lowest of: the actual charge billed by the physician or supplier; the charge the physician or supplier customarily bills patients for the same service; or the prevailing charge that most physicians or supliers in that locality bill for the same service. Increases in physicians' prevailing charge levels are granted only when justified by an index reflecting changes in the costs of practice and in general earnings.

Reasonable cost—In processing claims for health insurance (HI) benefits, intermediaries use Health Care Financing Administration guidelines to determine the reasonable cost incurred by individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers but excluding costs that are unnecessary for the efficient delivery of services covered by the HI program.

Recipient—A Medicaid recipient is an individual who has been determined to be eligible for Medicaid and has used any type of medical service covered by Medicaid.

Reimbursement—The reimbursement amount refers to the dollar amount of medical expenses payable by the Medicare program. (For Medicaid, see "expenditures.")

Rural health clinic—A rural health clinic is an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets certain other requirements designed to ensure the health and safety of the individuals served by the clinic. The clinic must be located in a medically underserved area that is not an urbanized area as defined by the Bureau of the Census and that is designated by the Secretary of Health and Human Services either as an area with a shortage of personal health services or as a health manpower shortage area. A rural health clinic must file an agreement with the Secretary not to charge individuals for items or services for which they are entitled to have payment made by Medicare. People are charged only for the amount of any applicable deductible or coinsurance.

Short-stay hospital—A short-stay hospital is one in which the average length of stay is less than 30 days. General and special hospitals are included in this category.

Skilled nursing facility—A skilled nursing facility is an institution that has a transfer agreement with one or more participating hospitals; is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients; and meets specific regulatory certification requirements.

Skilled nursing facility services—All services furnished to inpatients of a certified skilled nursing facility that meets standards required by the Secretary of Health and Human Services and billed by that facility are included.

Spend-down—Spend-down refers to a method by which an individual established Medicaid eligibility by reducing gross income through incurring medical expenses until net income (after medical expenses) meets Medicaid financial requirements.

State buy-in—State buy-in refers to the process by which a State provides supplementary medical insurance coverage for its needy eligible persons by paying their premiums according to an agreement with the Federal Government.

State plan—The Medicaid State plan is a comprehensive written commitment by a Medicaid agency to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

Supplemental security income (SSI)—SSI is a program of income support for low-income aged, blind, and disabled persons, established by Title XVI of the Social Security Act.

Supplementary medical insurance (SMI)—SMI (also known as Medicare Part B) is a voluntary insurance program for aged and disabled individuals who elect to enroll which provides insurance benefits for physician and other medical services in accordance with the provisions of Title XVIII of the Social Security Act. The program is financed by premium payments by enrollees and contributions from funds appropriated by the Federal government.

Third-party liability—Third-party liability exists if an entity (including other government programs or insurance) is or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

Utilization and Quality Control Peer Review Organization (PRO)—This is a statewide, nonfacility organization. Established by Public Law 97-248 (Social Security Act of 1983), it is a physician sponsored or physician access organization that enters into a contract with the Department of Health and Human Services (DHHS) to conduct utilization and quality control review for services and items that may be paid for by Medicare. The review responsbilities of PRO's include: admission review (preadmission, preprocedure, and review within 7 days of discharge), review of transfers, permanent cardiac pacemaker implantation review, quality review, diagnosis-related group validation, cost and stay outlier review, admission pattern monitoring, prospective payment system hospital denial review, reconsiderations, sanctions and review of abuse issues referred by other Medicare contractors, the Health Care Financing Administration or DHHS Office of the Inspector General. A hospital agreement with the PRO for PRO performance of utilization and quality control review will be a condition of payment under the Medicare prospective payment system. States may contract with a PRO for Medicare review.

Vendor—A medical vendor is an institution, agency, organization, or individual practitioner that provides health or medical services.

Appendix E
Medicare and Medicaid acronyms

AAPCC	Adjusted average per capita cost
AFDC	Aid to Families With Dependent Children
CFR	Code of Federal Regulations
CMHS	Continuous Medicare history sample
CON	Certificate of need
DHHS	Department of Health and Human Services
DRG	Diagnosis-related group
EAC	Estimated acquisition cost
EPSDT	Early and periodic screening, diagnosis, and treatment
ESRD	End-stage renal disease
FFP	Federal financial participation
FMAP	Federal Medicaid assistance percentage
GPPP	Group practice prepayment plan
HCFA	Health Care Financing Administration
HHA	Home health agency
HI	Hospital insurance
HMO	Health maintenance organization
ICF	Intermediate care facility
ICF-MR	Intermediate care facility for the mentally retarded
MAC	Maximum allowable cost
MMIS	Medicaid Management Information System
OBRA	Omnibus Budget Reconciliation Act
PPS	Prospective payment system
PRO	Peer review organization
PSRO	Professional standards review organization
SMI	Supplementary medical insurance
SNF	Skilled nursing facility
SSI	Supplemental security income
SSP	State supplemental payment
TEFRA	Tax Equity and Fiscal Responsiblity Act

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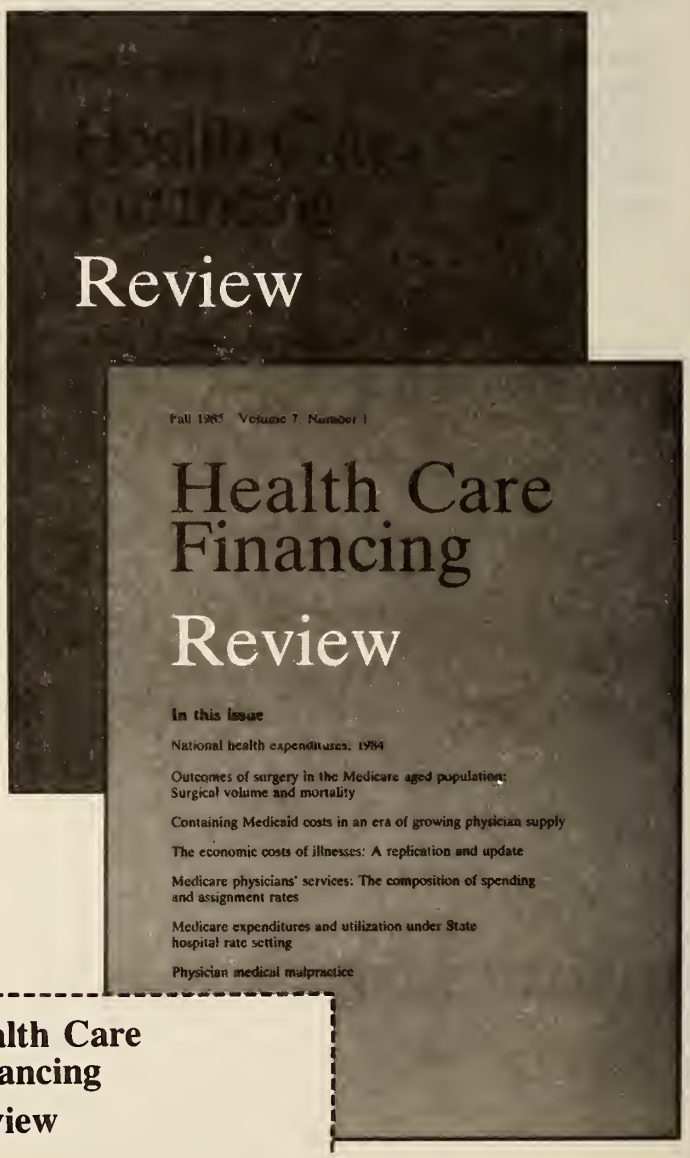
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